Evaluation of the Child Development Facility Accreditation Project

Final Report

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California Department of Education
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1430 N Street
Sacramento, California 95814

Submitted by:

Berkeley Policy Associates
440 Grand Avenue, Suite 500
Oakland, California 94610
BPA #699

Authors:

Phyllis Weinstock

Kalpna Mistry

María Ryan

Other Contributors:

Berkeley Policy Associates:

Johannes Bos
Megan Hague Angus
Maria Muniz

UCLA:

Carollee Howes
Billie Weiser
Sharon Ritchie
Gabrielle Veit

Stanfield Systems:

Christopher Nail
Tim Jacobs

Contents

Executive Summary

The Child Development Facility Accreditation Project (CDFAP), a statewide initiative designed to improve the quality of child care for thousands of low income and at-risk children, was a collaboration between the California Department of Education's Child Development Division, the California Association for the Education of Young Children (CAEYC), RISE Learning Solutions, and the California School-Age Consortium (CalSAC). Project implementation began in June 2001 and services were provided through the completion date of December 31, 2003. Funds for the CDFAP were provided both through the California Children and Families Commission, which provided $8 million, and the California Department of Education's Child Development Division, which provided $5 million. The California Department of Education contracted with Berkeley Policy Associates (BPA) to carry out an evaluation of the CDFAP, including both a process study and an outcomes study, beginning in January 2003 and concluding in December 2004. BPA partnered with UCLA and Stanfield Systems in conducting this evaluation.

The goal of the CDFAP was to recruit 370 child care centers and 900 family child care homes to participate in the accreditation process and to meet the standards necessary in order to ultimately attain accreditation status. In addition, twenty school-age child care centers were to be included through support from CalSAC. Participating child care centers were to be state-subsidized centers located in low-performing school districts. Participating family child care homes were required to provide care in targeted categories including infant care, care for children with special needs, care for children of families speaking limited English, and alternative hours care. The CDFAP was designed to make use of the existing accreditation systems, which includes National Association for the Education of Young Children (NAEYC), the National Association of Family Child Care (NAFCC), and the National After School Alliance (NAA), formerly known as the National School Age Care Alliance (NSACA). The accreditation process is costly and time-intensive, and each of the program/provider groups targeted for participation in the CDFAP faced barriers to accreditation. The CDFAP was designed to offer extensive assistance to providers in overcoming these barriers and successfully completing the process. Types of assistance to providers/programs included the following:

- Financial assistance for accreditation fees and for purchase of enhancement materials.
- Regional facilitators to guide providers/programs through the accreditation process, organize training activities, and provide individualized assistance.
- Facilitated broadcast trainings explaining each step of the accreditation process.
- Training module series in CD ROM/Internet or video/workbook format.
- Translations of training materials into Spanish, and bilingual facilitators available in some areas.
- Additional peer training and support in the form of monthly cohort meetings, bringing together small groups of center directors and family child care home providers in each county.

Actual attainment of accreditation status by most participants was expected to take place after completion of the project and was outside of the project's scope. The decision to accredit a program is made by the national accrediting body. The goal of the CDFAP in providing the above supports was to bring the required number of providers and programs to the "door" of accreditation no later than December 2003. The project's responsibility was to guide programs through all steps of the accreditation process up to and including submission of the final paperwork to the appropriate accrediting body.

The CDFAP was one among a variety of child care quality improvement projects undertaken in recent years in California and elsewhere. It is one of the largest projects to date to focus on accreditation. From its inception, the project presented a potential strain on the capacity of the three accreditation systems identified above. The CDFAP was charged with increasing the population of NAEYC-accredited child care centers in California by two-thirds, doubling the number of NAA/NSACA-accredited school-age programs, and increasing by a factor of eight the population of NAFCC-accredited family child care homes.

Design of the Evaluation

The evaluation began in January of 2003 and concluded in December 2004. Evaluation methods included:

- Interviews with project staff, including its central staff, five regional managers, and twenty-four accreditation facilitators stationed throughout the state.

- Analysis of data collected by the CDFAP project, including key characteristics of project applicants and participants, and reasons for attrition.
- Two rounds of observations, using Environmental Rating Scales, of a sub-sample of forty participating programs. The observation sample was selected randomly from among participating programs in five counties representing five regions of the state. Evaluator observation data were compared to baseline quality data collected by the project.
- On-site interviews and focus groups with participating programs in the five counties selected for observations, as well as interviews with other local stakeholders such as Resource and Referral Agencies and County First Five Commissions.
- A statewide participant survey, based on a stratified random sample of 100 centers and 100 family child care homes, administered in 2004, that addressed accreditation outcomes and participant satisfaction with the project.

Key Evaluation Findings

The following is a summary of the key evaluation findings presented throughout this report:

- The project succeeded in bringing about 340 subsidized child care centers, 740 family child care homes, and twenty school-age centers to the door of accreditation: these programs had submitted all or almost all accreditation paperwork by the project ending date and expected to complete the accreditation process. About one-third of the family child care providers had a primary language of Spanish and most family child care homes served infants, as did about 16 percent of the centers.

- Large numbers of the programs recruited in the early stages of the project, including over 2000 family child care homes and 200 centers, either never officially enrolled in the project or withdrew at some point during the process. Major reasons included failure to meet eligibility requirements, loss of interest, competing demands for time, and insufficient capacity in the CDFAP project itself that resulted in waiting lists for participation.

- Survey findings based on reports of a statewide sample of participants about nine months post-project found that 9 percent of centers, 39 percent of family child care homes, and 54 percent of centers had been officially accredited so far. These

differences among the program groups reflected differences in the capacity of the three accreditation systems to accommodate a surge in the numbers of applicants. Few survey participants had been denied accreditation, but most awaited scheduling of accreditation validator visits, or awaited official decisions after visits had been conducted. All or most programs expected to become accredited, but lengthy waits resulted in frustration and some additional work.

- Quality improvements resulting from the project were significant, according to the combined results of program observations, the participant survey, interviews, and focus groups. Improvements in staff-child interaction, children's social development, program materials and activities, and some areas of basic care, were realized by many participating programs and were sustained or enhanced for six months after project completion. Participants also reported that the project strengthened their networks with other professionals and their commitment to the child care field.

- Among the various services and supports offered by the project, participants reported the payment of accreditation fees and enhancement grants to be the most helpful, but most found the training and facilitation services to be helpful as well. Family child care providers were more likely than centers to participate in monthly support groups organized by the project, and were more likely than centers to rate the project's training resources as very helpful.

- Among the barriers to success that caused the most concern for survey respondents were the demands of extensive paperwork, conflicts caused by personal life challenges, and inconsistent availability of project facilitators. Needs for more translated materials were noted by both family child care providers and centers.

- Survey results suggest the project enhanced the capacity of participating programs to continually improve. More than six months after expiration of the CDFAP grant, most survey respondents (over 80 percent) reported continuing participation in professional development activities; about one-third reported receiving continued support for accreditation either through their own programs or through various individuals or local agencies; and over 60 percent of family child care providers and 30 percent of centers reported continuing contacts with professionals they had met through the project.

- Participants found the project very valuable, but expressed concerns about their ability to maintain their program quality over the long term without additional grants for training and materials, and about their ability to sustain/renew their accreditation status in the future without additional waivers of accreditation fees.

Lessons and Recommendations

Below are key lessons learned through the evaluation of the project, as well as recommendations for future accreditation support projects or other child care quality improvement projects:

- Regional and local differences should dictate differing approaches to accreditation and quality improvement.

- Increased public education about child care quality, along with greater public recognition of accredited programs, is needed.

- Recruitment and outreach materials for accreditation projects should make clear the level of commitment required to complete accreditation.

- Family child care homes need more support than centers in order to achieve accreditation, including smaller caseloads for facilitators in order to enable more frequent contact and individualized assistance.

- The waiting period for accreditation should be shortened, and support should be continued until accreditation is officially awarded.

- Accreditation is a valuable element of a quality child care/preschool system, and funding incentives for accreditation should be integrated into preschool initiatives.

Chapter One

Introduction

The Child Development Facility Accreditation Project (CDFAP) was a statewide initiative designed to improve the quality of child care for thousands of low income and at-risk children. In June 2001, the California Department of Education's Child Development Division contracted with the California Association for the Education of Young Children (CAEYC) and its partners, RISE Learning Solutions and California School-Age Consortium (CalSAC), to undertake this initiative, to be completed by December 31, 2003. Funds for the CDFAP were provided both through the California Children and Families Commission, which provided $8 million, and the California Department of Education's Child Development Division, which provided $5 million. The California Department of Education contracted with Berkeley Policy Associates (BPA) to carry out an evaluation of the CDFAP, including both a process study and an outcomes study, beginning in January 2003 and concluding in December 2004. BPA partnered with UCLA and Stanfield Systems in conducting this evaluation.

The goal of the CDFAP was to recruit 370 child care centers and 900 family child care homes[1] to participate in the accreditation process and to meet the standards necessary in order to ultimately attain accreditation status. Participating child care centers were to be state-subsidized centers located in low-performing school districts. Participating family child care homes were required to provide care in targeted categories including infant care, care for children with special needs, care for children of families speaking limited English, and alternative hours care.

The CDFAP was designed to make use of the existing accreditation systems of the National Association for the Education of Young Children (NAEYC), the National Association of

[1] All programs participating in the CDFAP were required to have current licenses through the Community Care Licensing Division of the California Department of Social Services. Licensing focuses on basic safety standards and group size. Family child care homes, which provide care for up to fourteen children in the providers' own homes, have different licensing standards than those of centers.

Family Child Care (NAFCC), and the National After School Alliance (NAA)[2]. Each of these systems promotes adherence to high standards of quality through structured processes of self-study, professional development, program improvement, and independent observation. The process is costly and time-intensive, and each of the program/provider groups targeted for participation in the CDFAP faces barriers to accreditation. The CDFAP was designed to offer extensive assistance to providers in overcoming these barriers and successfully completing the process.

Among the types of assistance offered by the CDFAP were the following:

- Financial assistance for accreditation fees and for purchase of enhancement materials.
- Regional facilitators to guide providers/programs through the accreditation process, organize training activities, and provide individualized assistance with ordering of enhancement materials, implementation of enhancements, and preparation of all required paperwork.
- A series of facilitated broadcast trainings, familiarizing participants with each step of the accreditation process.
- A series of training modules, to be accessed by providers/programs either via CD ROM/Internet or via video/workbook format.
- Translations of training materials into Spanish, and bilingual facilitators available in some areas.
- Additional peer training and support in the form of monthly cohort meetings, bringing together small groups of center directors and family child care home providers in each county.

It is important to note that the actual attainment of accreditation status by most participants was expected to take place after completion of the project and was outside of project's scope. The decision to accredit a program is made by the national accrediting body. The goal of the CDFAP in providing the above supports was to bring the required number of providers and programs to the "door" of accreditation no later than December 2003. The project's responsibility was to guide programs through all steps of the accreditation process up to and including submission of the final paperwork to the appropriate accrediting body. At this point, having aided the program in meeting the quality standards and submitting all required paperwork, the CDFAP no longer had control over the accreditation process. The national

[2] The National After School Association was formerly called the National School-Age Care Alliance.

accrediting body, whether NAEYC, NAFCC, or NAA, necessarily takes over the final steps. In each system these steps include deployment of a "validator"[3] to conduct an independent program observation and make a recommendation to the national accrediting body, which ultimately makes a final decision regarding accreditation.

Context of the Child Development Facility Accreditation Project

The CDFAP is one among a variety of child care quality improvement projects undertaken in recent years in California and elsewhere. Many of these projects have been funded by states through the use of federal Child Care and Development Funds. A 2002 study of 104 state child care quality initiatives identified accreditation as one of four national models used by states to improve child care quality (Porter, 2002). In the study findings, published by the Bank Street College of Education, six states (not including California) were identified as using accreditation as a primary strategy for statewide child care quality improvement. Many other states and local areas have conducted accreditation facilitation projects on a smaller scale. The CDFAP was one of the largest projects to date to focus on accreditation, encompassing 51 counties in California and aiming to ultimately achieve accreditation for a total of 900 family child care homes and 370 centers.

From its inception, the project presented a potential strain on the capacity of the three accreditation systems. The CDFAP was charged with increasing the population of accredited child care centers in California by two-thirds, doubling the number of NSACA/NAA accredited school-age programs, and increasing by a factor of eight the population of accredited family child care homes. Prior to the initiation of the CDFAP, only 563 California child care centers, 113 family child care homes, and 22 school-age programs had been accredited by their respective systems. Nationally, prior to the CDFAP, 7700 centers, 2500 family child care homes, and 217 school-age programs had been accredited (California Association for the Education of Young Children, 2001). All three systems faced a limited supply of the volunteers they rely upon to conduct the validation visits required to finalize the accreditation process. Within the NAEYC accreditation system, programs submitting final paperwork for accreditation faced waits of up to a year for a validator visit, and up to an additional six months for a final accreditation decision.[4] The expected infusion by the

[3] The individual responsible for the final observation and recommendation in the NAEYC system is called a "validator," in the NAFCC system an "observer" and in NAA an "endorser."
[4] Estimated wait times are based on information provided by representatives of accrediting bodies at CDFAP Advisory Committee Meetings in 2003. Wait times within the NAFCC (family child care) system were reported to be shorter, approximately three to six months.

CDFAP of a large number of new applicants for accreditation within a few years' time had the potential to worsen this bottleneck, in the absence of system expansion.

Research on Accreditation

Numerous studies have found that accreditation increases the quality of child care. The Early Childhood Environment Rating Scale (ECERS) and the Family Day Care Rating Scale (FDCRS) are widely used to assess the quality of child care. The ECERS is among the measures used in previous studies that assess the outcomes of NAEYC accreditation (Howes and Galinsky, 1996), and that compare quality in accredited and non-accredited child care centers (Whitebook, et al, 1997; Whitebook et al, 2001). The FDCRS is a key measure in studies of family child care home quality (Kontos, 1995; FPG-UNC, 2000).

- A study by Whitebook et al (2001) of 43 centers in Northern California found that centers that were accredited in both 1996 and 2000 had a mean ECERS score of 5.31 compared to a mean score of 4.02 among centers not accredited at either time.
- In a comparison of accredited and non-accredited centers in 2002, the Wisconsin Child Care Research Partnership (2002) reported mean ECERS scores of 4.60 for accredited centers, compared to 4.03 for non-accredited centers.
- In an evaluation of Smart Start, a child care quality initiative in North Carolina, the Frank Porter Graham Child Development Center (2000) reported that family child care homes with NAFCC accreditation had an FDCRS mean score of 3.85, compared to 3.51 among homes lacking accreditation.
- In an evaluation of a large child development center undergoing NAEYC accreditation, Howes and Galinsky (1996) found that ECERS scores increased significantly after accreditation.

Research has also shown that there are many barriers to programs' entry into and successful completion of the accreditation process. These barriers include the cost, time, and commitment required to complete the process, and the lack of economic incentives for most providers. Barriers are most severe for family child care providers, especially non-English-speaking providers. The CDFAP was explicitly designed to address many of these barriers, and was able to build on the experiences of other facilitation projects. However, the CDFAP undertook this task on a scale that had not been previously attempted, and offers an unprecedented opportunity to learn about effective strategies for promoting accreditation in a diverse statewide child care community.

Design of the Evaluation

The evaluation began in January of 2003 and concluded in December 2004. The goal of the evaluation was to address a series of questions about both process and outcomes, presented in Figure 1.1. The evaluation used a combination of research methods to address these questions. These methods included:

1. **Interviews with project staff** (including central staff, the five regional managers, and twenty-four project facilitators stationed throughout the state). These interviews were conducted by telephone between February and May of 2003. They were supplemented by a review of project documents and training materials.

2. **Analysis of project data.** The CDFAP staff shared with BPA its database that included key characteristics of all participating programs. CDFAP staff also shared more extensive programmatic and assessment data (including baseline assessments) on those programs selected by BPA to participate in observations.

3. **Observations of a sub-sample of participating programs in two rounds**, one year apart. Participating centers and family child care homes were randomly selected from each of five counties (or local service areas encompassing parts of counties or clusters of counties) representing major geographic regions of the state. Sixteen centers and fifteen family child care homes participated in both rounds of observations. Programs were assessed at both time points using the ECERS, the FDCRS, and the Infant Toddler Environment Rating Scale. These measures were supplemented by brief interviews with program staff and by project data, including baseline program assessments. The counties selected for site visits included: Alameda County, Sutter/Yuba Counties, Fresno/Tulare Counties, East Los Angeles County, and San Diego County. The counties were selected to represent major regions of California: Northern California (both urban and rural counties); Central California (mixed urban/rural-agricultural area with many farm workers); and Southern California (two major urban counties, including one bordering on Mexico).

4. **On-site interviews and focus groups.** At the time of Round One visits described above, BPA supplemented the program observations with data gathered on project implementation in the local area. In four of the five counties, site visitors observed a cohort training session and led a focus group discussion among the training participants. Evaluators also conducted interviews with key stakeholder organizations in each of the five selected counties. Organizations interviewed in each county varied based on local partnerships identified by the facilitators; those

included were County First Five Commissions, Resource and Referral Agencies, and Local Child Care Planning Councils.

5. **A statewide participant survey**, based on a stratified random sample of 100 centers and 100 family child care homes, was administered in 2004. This survey addressed accreditation outcomes and participant satisfaction with the project.

Figure 1.1 shows the correspondence between these data sources (as numbered above) and the major research questions addressed by the evaluation.

Figure 1.1
Data Sources for Key Research Questions

Research Questions	Key Research Methods/Data Sources
Process Study	
How were CDFAP partners identified and selected, and what are their respective roles? What collaborative activities at the partnership level originated specifically for CDFAP implementation? How effective are they? What collaborative associations, partnerships and activities at the local levels originated as a result of CDFAP implementation? How effective are they?	1,4
What outreach strategies characterize the CDFAP? How effective have they been in identifying target populations?	1,2,4
How are the participants receiving training and support identified through this project? What type of training and support is being offered and utilized?	1,2,4
How much time is required and how many participants complete the training?	1,2
What technical assistance is being provided? How effective is the technical assistance?	1,4,5
How does the disbursement of funds to child development centers and FCCHs for accreditation costs occur? How effective is the disbursement system?	1,4,5
What barriers and indicators of barriers have been identified?	1,4,5
Outcomes Study	
What is the ratio of applicant facilities to facilities achieving accreditation? (or meeting the various benchmarks on the way to accreditation) What are the characteristics of the participants overall, and of those who complete the key steps of the process?	2, 5
At what point do participants withdraw from the training and/or the accreditation process and for what reasons?	2,5
What programmatic and procedural changes were made as a result of CDFAP self-assessments? What changes are sustained beyond the life of the project?	3, 4, 5
How does the quality of the programs that have completed the CDFAP process compare to the quality of other programs as reported in state and national studies?	3
What system changes or other secondary outcomes that strengthen or modify the accreditation process have been identified? How effective are they? What recommendations result?	1,4
Cost Effectiveness Study	
How efficient are the systems for outreach, technical assistance, training and disbursement of funds?	All

The NAEYC and NAA accreditation systems are currently undergoing extensive reform and revisions, and the effectiveness of the revised systems should be the subject of future research. This evaluation focused not on the national accreditation systems but on the attainment by the CDFAP of its own project-specific goals and implementation of project-controlled activities. However, the attainment of accreditation status was the ultimate goal of the participants and their reason for entering the project. Therefore, the evaluation did address accreditation outcomes, while taking into account systemic factors that may have influenced these outcomes.

This Final Evaluation Report incorporates the findings of the Interim Evaluation Report, produced in April 2004, that addressed project implementation and preliminary outcomes based on project participation data and the first round of program observations. The current report completes the evaluation through a comparison of the two rounds of observations and analysis of results of the participant survey. These recent data collection activities have produced additional findings on accreditation outcomes and effectiveness of project services. The report concludes with a synthesis of all findings and recommendations.

Chapter Two

Accreditation Outcomes

The key goal of the Child Development Facility Accreditation Project (CDFAP) was to bring targeted programs to the door of accreditation—including completion of all self-study and application materials—by December 2003. The CDFAP proposal set forth numeric goals of 370 subsidized child care centers and 900 family child care homes, while acknowledging that a more realistic expectation, based on past research, was to reach about 90 percent of these targets. Participating centers were required to be located in low performing school districts, and programs serving non-English-speaking families, children with special needs, and infants were to be prioritized. The challenges involved in reaching and retaining programs, especially family child care homes, of this number and profile were acknowledged to be formidable.

The evaluation was designed to track the success of the project in reaching these targets for completion of steps towards accreditation, as well as to conduct follow-up research to investigate participants' actual attainment of accreditation status. The primary method for the former was analysis of participant data provided by the project, while the primary method for the latter was a participant survey. These data sources and results are described below.

Characteristics of Project Participants

In the final project report submitted to the California Children and Families Commission in February 2004, the CDFAP staff reported the following final status of participants[5]:

- 738 family child care homes reached the "door" of accreditation.
- 10 family child care homes continued to pursue accreditation through "self-study."
- 345 child care centers reached the "door" of accreditation.

[5] For clarification of the steps of the accreditation process and definition of terms, see the websites of the accrediting bodies: www.naeyc.org, www.nafcc.org, and www.naaweb.org.

- 4 child care centers continued to pursue accreditation through "self-study."
- All 20 school-age programs facilitated through CalSAC completed the requirements for accreditation.

These numbers indicate that the project reached about 80 percent of its target for family child care homes, over 90 percent of the target for centers, and 100 percent of its target for school-age programs. This achievement is comparable to the estimate presented by the original CDFAP proposal, based on the reports of previous accreditation projects.

Based on a participant database provided to the evaluators by project staff in December 2003, it was not possible to identify with certainty those participants who succeeded in reaching the door of accreditation. However, BPA did identify the following relevant groups:

Among family child care homes:

- 769 family child care homes that were clearly selected for enrollment in the project, and were retained (no indication of having been dropped) as of December 19, 2003. This assumes that this group includes the 738 homes that were subsequently identified by the project as having made it to the door of accreditation.
- 447 family child care homes that were clearly identified as having been deselected or dropped from the project.
- 1734 family child care homes that were not clearly identified as having been either selected, deselected, or dropped but that appear, in most cases, to have not completed the screening process. The fields for descriptors of these programs are largely empty, probably because most of the programs did not complete even the initial screening form designed to collect basic program information.

Among child care centers:

- 360 centers that were clearly selected for enrollment in the project, and had not been identified as dropped as of December 19, 2003, including 10 that were identified as having already submitted their final accreditation packet. This assumes that this group includes the 345 centers that were subsequently identified by the project as having made it to the door of accreditation.
- 230 centers that were clearly identified as having been deselected or dropped from the project.
- 3 centers not clearly identified as having been selected, deselected or dropped.

Figure 2.1 presents the key characteristics of the programs that were identified in the database as either still participating or dropped as of December 2003. Service characteristics of programs that left the project were, overall, similar to those of programs that were retained. As noted above, evaluators expect that the "retained" program group approximates the group that successfully completed the project. Figure 2.1 indicates that almost one-third of these family child care providers had a primary language of Spanish, and over half served non-English-speaking children. Over half served children with disabilities and almost 90 percent served infants. Fewer characteristics are available for centers, but Figure 2.2 shows that over 17 percent of centers retained in the project served infants and 35 percent served toddlers. BPA did not analyze the distribution of center operators, but observed that centers included a variety of community-based nonprofits, college and university programs, and Head Start programs (including Migrant Head Start programs), along with state preschools and numerous school district-operated child development centers.

With the exception of only a few family child care providers, Spanish is the only language other than English identified as a "primary language." However, a database field on "other languages spoken" by both retained and dropped family child care providers identified a wide variety of languages including Persian, Farsi, Cantonese, Ukranian, Korean, Tagalog, and Arabic.

Figure 2.1
Characteristics of CDFAP Family Child Care Homes
December 2003

	Family Child Care Homes Retained in Project		Family Child Care Homes Dropped	
	Number	Percent	Number	Percent
Total	769	100.00	447	100.0
Provider's Primary Language				
English	527	68.53	300	67.11
Spanish	241	31.34	122	27.29
Russian	1	0.13	1	0.22
Vietnamese			1	0.22
Not coded			23	5.15
Service to Target Groups				
Infant	676	87.91	388	86.80
Infant/Toddler	92	11.96	67	14.99
Children w/disabilities	403	52.41	202	45.19
Non-English-speaking	418	54.36	232	51.90

Figure 2.2
Characteristics of CDFAP Centers
December 2003

	Centers Retained in Project		Centers Dropped	
Total	360	100.0	230	100.0
Serves Infants	61	16.94	24	10.43
Serves Toddlers	125	34.72	66	28.70

The Participant Survey

Evaluators designed a survey to assess accreditation outcomes, as well as service participation and satisfaction, based on a representative statewide sample of project participants. The survey was administered in late summer through fall of 2004, or approximately nine months after completion of the CDFAP grant.

Variants of the participant survey were designed for child care centers and for family child care homes, and a Spanish version was created for the Spanish-speaking family child care providers. Stanfield Systems, BPA's subcontractor, developed web-based surveys for all three versions. Based on the final database of participants that BPA received from CAEYC in December 2003, BPA drew a sample of 100 family child care providers and 100 centers. The survey sample was designed to include all 42 programs that were part of the observation sample, with the remainder of the survey sample drawn randomly from designated strata. The strata included Spanish-speaking family child care providers, English-speaking family child care providers, centers not serving infants, centers serving infants, and all counties. The sample included at least one program from each county that had any participating programs; 31 Spanish-speaking family child care providers; 69 English-speaking family child care providers; 26 child care centers serving infants; and 73 centers not serving infants.

Surveys were mailed in July through August of 2004, and participants were given a choice of completing the surveys by mail or on-line. In addition, telephone follow-up was conducted in August through October. The final response rate was over 70 percent for both centers and family child care homes. Figures 2.3 and 2.4 below present the respondent characteristics. Center respondents were located in 33 different counties and family child care respondents represented 40 counties.

A separate telephone survey was conducted of the school-age programs participating in the CDFAP; these programs had received a distinct set of services that were facilitated through the California School-Age Consortium. Evaluators reached thirteen of the twenty participating school-age programs.

Figure 2.3
Survey Respondent Characteristics: Centers

	Number	% of Final Sample
Centers (Total)	74	100.00
Serve Infants (under 2)	26	35.14
Serves Children with Special Needs	51	68.92
Serves Children with Primary Lang Not English	65	87.84

Figure 2.4
Survey Respondent Characteristics: Family Child Care Homes

	Number	% of Final Sample
Family Child Care Homes (Total)	71	100.00
Spanish-Speaking Providers	23	32.39
Serves Children Under 2	52	73.24
Serves Children w Primary Lang not English	34	47.89
Serves Children with Special Needs	33	46.48
Licensed for fewer than 12	24	33.80

Survey Findings on Accreditation Status

Survey findings supported the project's estimate that participants retained in the project database had reached the door of accreditation. Almost all survey respondents reported having completed all paperwork for accreditation; the exceptions were one family child care home that had withdrawn from the process and five family child care homes that had not yet

submitted paperwork but expected to do so soon. The vast majority of respondents reported submitting final accreditation paperwork in 2003; a handful had done so in early 2004 or late 2002.

Figure 2.5 presents the respondents' accreditation status at the time of survey completion, while Figure 2.6 provides a visual comparison of center and family child care outcomes. About 9 percent of centers and 38 percent of family child care homes had been accredited, reflecting the shorter waiting period for a validator visit in the NAFCC system than in the NAEYC system. (These system capacity issues are discussed on page 1.3.) The largest group of centers (over 40 percent) continued to await scheduling of the validator visit. The second largest group of centers (31 percent) and over 16 percent of family child care homes had had visits but continued to await official accreditation decisions. Large groups of centers (13 percent) and family child care homes (38 percent) awaited visits that had been scheduled and were expected to occur within a few months. While none of the family child care homes responded that they had been denied official accreditation, two centers did receive denials. One center stated that accreditation was deferred for two reasons: "supervision issues in two classrooms, and room tone in two classrooms." This center plans to put in a request for a revisit.

A larger proportion of school-age program respondents had been accredited (54 percent), at the time of the interviews. The number of CDFAP programs participating in this component (twenty) was far smaller than the others and did not generate comparable pressures on the accreditation system. Nevertheless, the NAA accreditation system also faced a problem of insufficient capacity, and reported that it paused the acceptance of new applications between August 2003 and September 2004 in order to complete processing of applicants already on a waiting list.[6]

While evaluators expect that most or all of the programs that are in the accreditation process will soon be accredited, the delays have been the cause of discouragement. When asked to comment on the project, eight center directors and eight family child care providers commented on frustration due to lengthy waits and/or lack of contact from the accrediting bodies during the period of attempting to schedule the validator visit. When interviewed, school-age child care center directors also expressed similar concerns. The long interval between completion of accreditation paperwork and visit from the validator (as long as a year) meant that some programs needed to update or even fully redo their accreditation self-assessment forms and questionnaires.

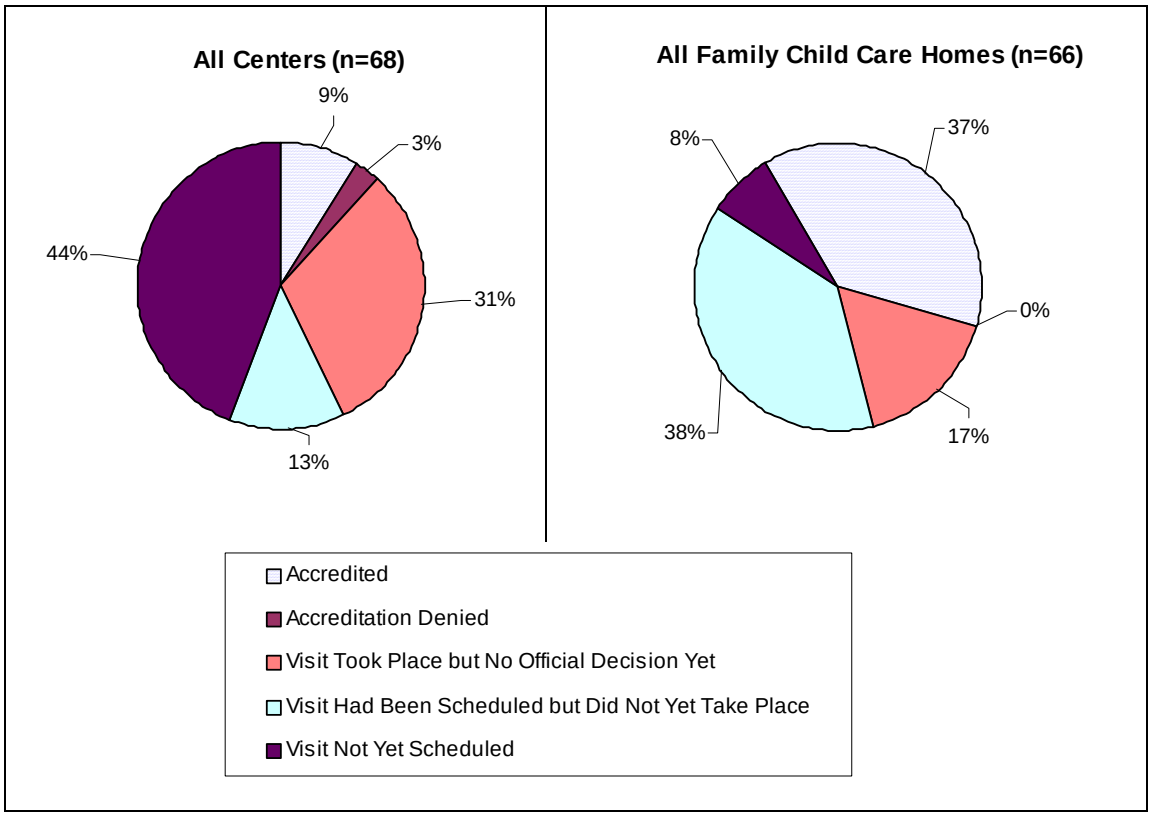
[6] See www.naaweb.org/accreditation.htm

While the CDFAP project officially ended in December 2003, it should be noted that many participating programs did continue to participate in child development classes and to share information with other providers whom they had met during the course of the project. A smaller proportion of programs also continued to receive support for accreditation through local agencies, or even through a former CDFAP facilitator. Survey results on these ongoing supports are discussed in Chapter Five. The availability of these supports makes it more likely that programs will continue to pursue accreditation status even in the face of delay, and also that they will continue to maintain or improve their programs' quality.

Figure 2.5
Accreditation Status at Time of Survey
Based on Respondents with Completed Accreditation Paperwork

	Accredited	Accreditation Denied	Visit Took Place but No Official Decision Yet	Visit Had Been Scheduled but Did Not Yet Take Place	Visit Not Yet Scheduled
All Centers (n=68)	8.8	2.9	30.8	13.2	44.1
Infant Centers (n=25)	8.0	4.0	24.0	20.0	44.0
All Family Child Care Homes (n=66)	37.9	0.0	16.7	37.9	7.6
Spanish Primary Language Family Child Care Homes (n=22)	31.8	0.0	18.2	4.6	45.5
School-Age Centers (n=13)	53.8	0	0	7.7	38.5

Figure 2.6
Accreditation Status at Time of Survey
Based on Respondents with Completed Paperwork



Chapter Three

Quality Outcomes

The evaluation measured the contribution of the Child Development Facility Accreditation Project to child care quality by using a combination of qualitative and quantitative methods. During the first round of site visits, evaluators conducted focus groups of project participants in which quality improvements resulting from the project were discussed. Following up on these open-ended discussions, the participant survey in 2004 asked respondents to rate the project's role in creating a variety of specific program improvements. The primary method for measuring quality was through observations of a sub-sample of CDFAP programs at two points in time approximately one year apart. These observations, using Environmental Rating Scales, were supplemented with baseline quality data provided by the project. Details of each of these methods, as well as findings, are discussed below.

Observation Sample

An important component of the evaluation was the selection of a sample of participating child care centers and family child care homes, totaling about forty programs, to participate in two rounds of observations. BPA conducted the observations using the Family Day Care Environment Rating Scale (FDCRS), the Early Childhood Environment Rating Scale (ECERS), and the Infant Toddler Environment Rating Scale (ITERS)[7]. The observations enabled evaluators to compare child care quality of CDFAP programs at several points in time, as well as to compare CDFAP program quality to that of average community child care programs as reported in other studies conducted in California and elsewhere. Round One

[7] The FDCRS is designed to assess family child care programs (programs operated in a provider's home) for children from birth through age five. The ECERS is designed to assess child care centers for children of preschool through kindergarten age (two through five years). The ITERS is designed to assess centers serving children from birth through 30 months of age. Further details can be found at the Frank Porter Graham Child Development Institute website, http://www.fpg.unc.edu/~ecers/

observations were conducted between August and November of 2003, and Round Two observations were conducted approximately one year later.

Programs to be observed were selected from the five counties listed in Chapter One. A stratified random sample of 42 programs, including 17 centers and 25 family child care homes, was selected using the project list of participating programs in each of the five site visit counties. Eight programs were selected from each of four counties and ten were selected from East Los Angeles. Within centers with multiple classrooms, one classroom was randomly selected for observation. The sample was stratified in order to represent the CDFAP's targeted service populations adequately, including family child care homes and centers, limited-English-speaking populations, and infants.

For Round One observations, a replacement sample in each county was used in the event of refusals to participate by the programs initially selected. BPA invited programs to participate by letter, followed by a telephone call. A few family child care providers in the original sample were unable to participate because of vacation plans, concerns about too many visitors (one was expecting an accreditation observer), or uncertainty about continued participation in the project. These providers were replaced using the randomly selected replacement samples. However, Round Two observations were limited to those participants in Round One who were able and willing to participate again. Because of program closures or declinations to participate a second time, the Round Two sample was limited to sixteen child care centers and fifteen family child care homes. Figures 3.1 and 3.2 below present the characteristics of the samples and the reasons for attrition between Round One and Round Two.

Figure 3.1
Observation Sample

	Round One	Round Two
Total Child Care Centers	17	16
Centers Serving Infants	4	4
Total Family Child Care Homes	25	15
Home with Spanish-Speaking Provider	11	9
Grand Total	42	31

Figure 3.2
Observation Sample: Reasons for Attrition Between Round 1 and Round 2

	Declined	Closed or Unable to Contact	Unable to Schedule	Total Withdrawals
Centers Not Serving Infants	1	0	0	1
Centers Serving Infants	0	0	0	0
Family Child Care Homes with English-Speaking Provider	4	4	0	8
Family Child Care Homes with Spanish-Speaking Provider	1	0	1	2
Total	6	4	1	11

The sampled programs, like most in CDFAP, entered the project between March and November of 2002. At the time of Round One observations (summer/fall 2003), most of the programs (37) reported that they had recently submitted their final paperwork for accreditation or expected to do so within the next few months. The remaining programs indicated some uncertainty about whether they would complete the process. At the time of the Round Two observations, the programs that continued to participate had either attained accreditation, had submitted paperwork but still awaited validator visits, or had recently had validator visits and awaited the results.

Baseline Data

Because BPA was able to conduct the first round of observations only after the project was well underway (and in fact, nearing completion), baseline quality data on the programs in the observation sample were provided by the CDFAP staff. These data were collected by CDFAP facilitators upon programs' entry into the project, using program observation tools designed by the accrediting bodies. These tools identified accreditation standards not yet fully met by the programs and were used by the project as a basis for developing enhancement plans that would enable each program to attain accreditation standards. Thus these baseline measures provided useful quality data but were not directly comparable to the Environmental Rating Scales. BPA undertook a process of partially aligning these measures with the Early Childhood Environment Rating Scale and the Family Day Care Rating Scale so that differences between baseline quality and Round One quality could be measured; this analysis is discussed later in this chapter and in Appendix A.

Comparison of CDFAP Sample Quality to Community Quality

Evaluator observations during both rounds found a relatively high level of overall quality among the sampled CDFAP programs. The Environmental Rating Scales rate programs on a scale from 1 to 7, with descriptors for 1(inadequate), 3 (minimal), 5 (good) and 7 (excellent).[8] CDFAP sample scores were consistently above the level of good, and were generally higher than those reported in community studies elsewhere. Figure 3.3 compares average CDFAP sample scores to those obtained in assessments of over six thousand programs in the State of North Carolina over the past five years. These programs had volunteered to participate in North Carolina's Star Rated License Project and therefore were assumed to be of higher than average quality. Nevertheless, CDFAP sample scores in each round and category were at least equal to and usually higher than the North Carolina scores.

Figure 3.3
Environmental Rating Scales:
CDFAP Sample and North Carolina Star-Rated Scores,
Comparison of Global Averages

	CDFAP Round 1 (N=42)	CDFAP Round 2 (N=31)	North Carolina*
ECERS	5.19	5.67	5.03
ITERS	6.13	6.19	4.7
FDCRS	5.10	5.36	5.1

*"North Carolina Rated License Assessment Project,"www.ncrlap.org

Figure 3.4 below compares the Round One global quality scores of CDFAP programs to those reported by studies of representative community programs (Kontos, 1995; Helburn and Howes, 1996; Peisner-Feinberg, 2001). The average scores for all three types of programs were significantly higher in the CDFAP programs than in the community programs. The average global score for each of the program types in the CDFAP was higher than 5.00.

[8] Further details on scoring methods can be found at www.fpg.unc.edu/~ecers/

A categorical variable was created that considered scores on any of the measures of less than 3.00 as unacceptable in quality, scores between 3.00 and 4.99 as marginal, and scores of 5.00 and above as good in quality. The CDFAP programs had no scores in the unacceptable category, 43 percent in the marginal category and 57 percent in the good category. Although it could be argued that 43 percent marginal in quality is not sufficient for an accreditation project, this distribution was significantly better than the community-based samples (χ (4) = 66.44, p < .001). In the community-based family child care programs the distribution was: 22 percent unacceptable, 73 percent marginal, and 5 percent good; and for centers: 8 percent unacceptable, 64 percent marginal, and 27 percent good.

Figure 3.4
Comparison of Average ERS Round One Scores to Community Scores

	CDFAP		Community		F
	Mean	SD	Mean	SD	
ECERS	5.19	.78	4.47	.94	7.11**
ITERS	6.13	.11	3.75	.87	29.24**
FDCRS	5.10	.89	3.61	.83	66.65**

Note: ** p <.01

Comparison of Baseline Quality to Round One Quality

As noted above, pre-project quality data were available only in the form of the accreditation baseline observation tool, which identified accreditation standards not met or not fully met by the programs. In order to enable a comparison of baseline quality to quality observed by BPA during Round One observations using Environmental Rating Scales, evaluators undertook a partial "crosswalk" of the accreditation standards and the FDCRS/ECERS measures. The methods of this crosswalk are discussed in Appendix A. Because only four centers were observed using the ITERS, evaluators chose not to crosswalk the ITERS with accreditation standards at this time. Using the baseline data provided by the CDFAP staff, evaluators focused on those accreditation standards that were: 1) frequently not met at baseline; 2) clearly comparable to items on the ECERS/FDCRS scales; and 3) based on observation rather than interviews (because of our assumption that observational data were more reliable and more directly comparable than interview data). On the basis of these criteria, evaluators

selected analysis standards generally found in the categories of environment, materials, learning activities, and staff-child interactions, rather than in those of parent relations, administration, or staff development.

Alignment of the accreditation standards with ECERS/FDCRS is a complex task, because of the systems' different approaches to organizing and scoring indicators of quality. The NAFCC/NAEYC standards are organized as a series of numerous specific indicators (about 300 NAFCC standards and 150 NAEYC standards), grouped by six or eight major categories. Each indicator, or standard, is assessed by an observer as "met," "not met," or "partially met." In contrast, the ECERS and FDCRS are based on 30 to 40 "items," or categories of care, each of which is scored by an observer using a structured series of indicators corresponding to scores 1 through 7.

Despite these differences in structure, the dimensions of quality measured by both systems closely parallel one another, and evaluators found the indicators of "good" quality and of standards "met" to be well aligned. This alignment is discussed in detail with respect to both the FDCRS and ECERS in Appendix A.

Having completed the crosswalk, evaluators compared quality measured at baseline to quality measured at the time of the Round One observations. "Passing rates" were constructed for each of the care categories identified, enabling us to observe change in these passing rates after approximately one year of participation in the project. For each category, the percentage of programs having "fully met" all relevant standards at baseline was compared to the percentage of programs achieving a score of 5.0 or better on the comparable ECERS/FDCRS items.[9] This comparison, while imperfect, provides a view of quality in important dimensions of care at two points in time.

Figures 3.5 and 3.6 present the category-specific comparisons of baseline and Round One quality for family child care homes and centers, respectively. Family child care homes show significant improvement between baseline and Round One in seven categories: safety, encouragement of reasoning skills, encouragement of language development, materials for large and small motor development, dramatic play, diapering/toileting, and art. In five other categories, passing rates did not change significantly between baseline and round one follow-up, and remained reasonably high at both time points. These categories include space arrangement, furnishings, discipline, music, and tone. In five other categories, quality

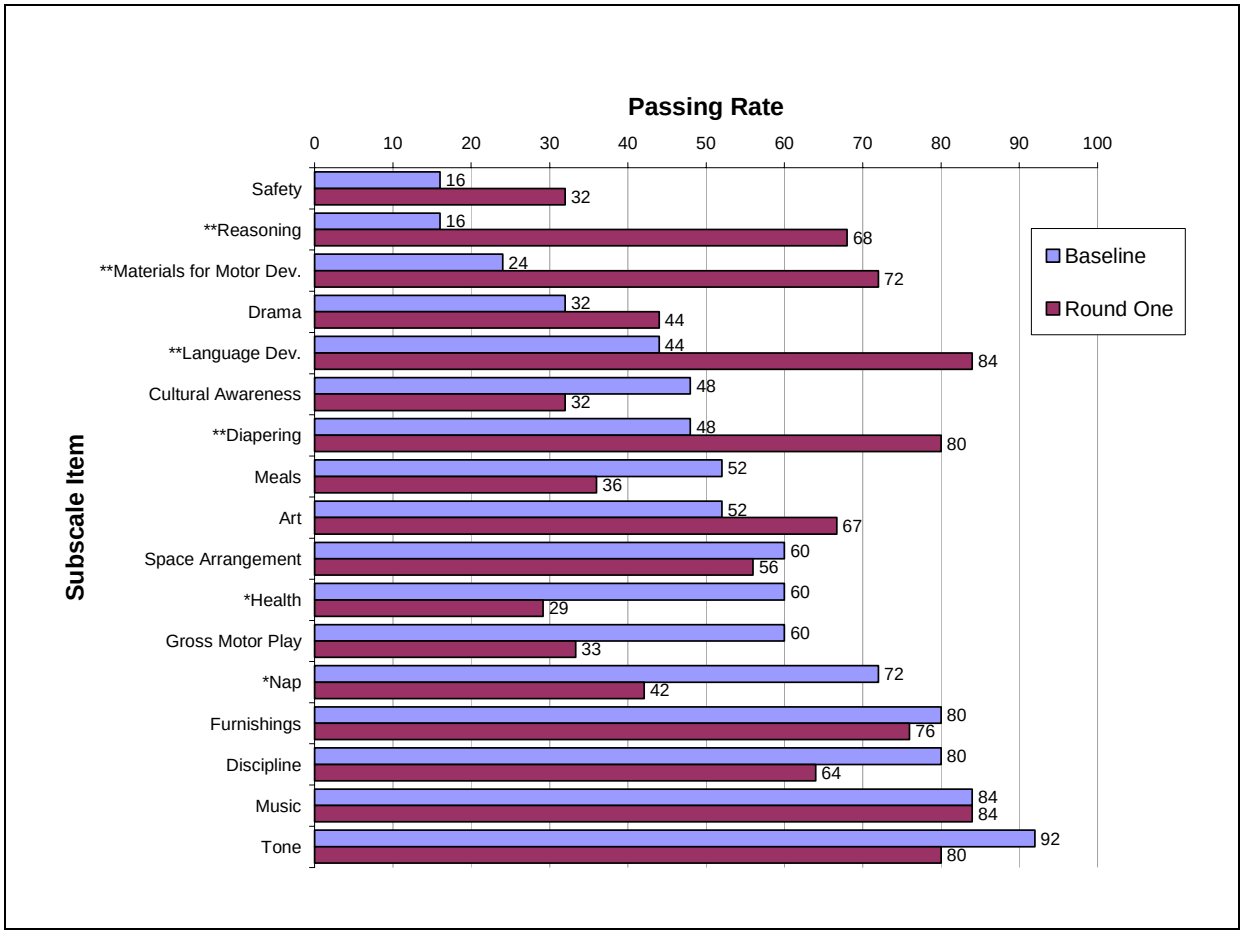
[9] All standards not identified in the baseline database as either unmet or partially met were considered to be fully met. When more than one ECERS/FDCRS item corresponded to a category, relevant item scores were averaged and an average of 5.0 or more was considered "passing."

appeared to drop between baseline and Round One: cultural awareness, meals, health practices, gross motor play, and nap.

Since our alignment of the accreditation standards and FDCRS is not exact, BPA cannot conclusively determine whether these apparent increases and decreases represent true changes in quality on these dimensions, or subtle differences in the scoring approaches of the different measures. An important difference between the two measures is that the accreditation score is a direct measure of "passing" versus "not passing", whereas the FDCRS is a more fine-grained measure, which may produce more marginal results. An overview of item-level FDCRS scores, presented in Figure A.8 in Appendix A, confirms this, indicating that many item scores were close to but slightly below the "passing" score of 5.0. For example, although only 32 percent of programs achieved a passing score of 5.0 or higher on the FDCRS cultural awareness item, the average score was 4.44, indicating that many programs were very close to the "passing" level.

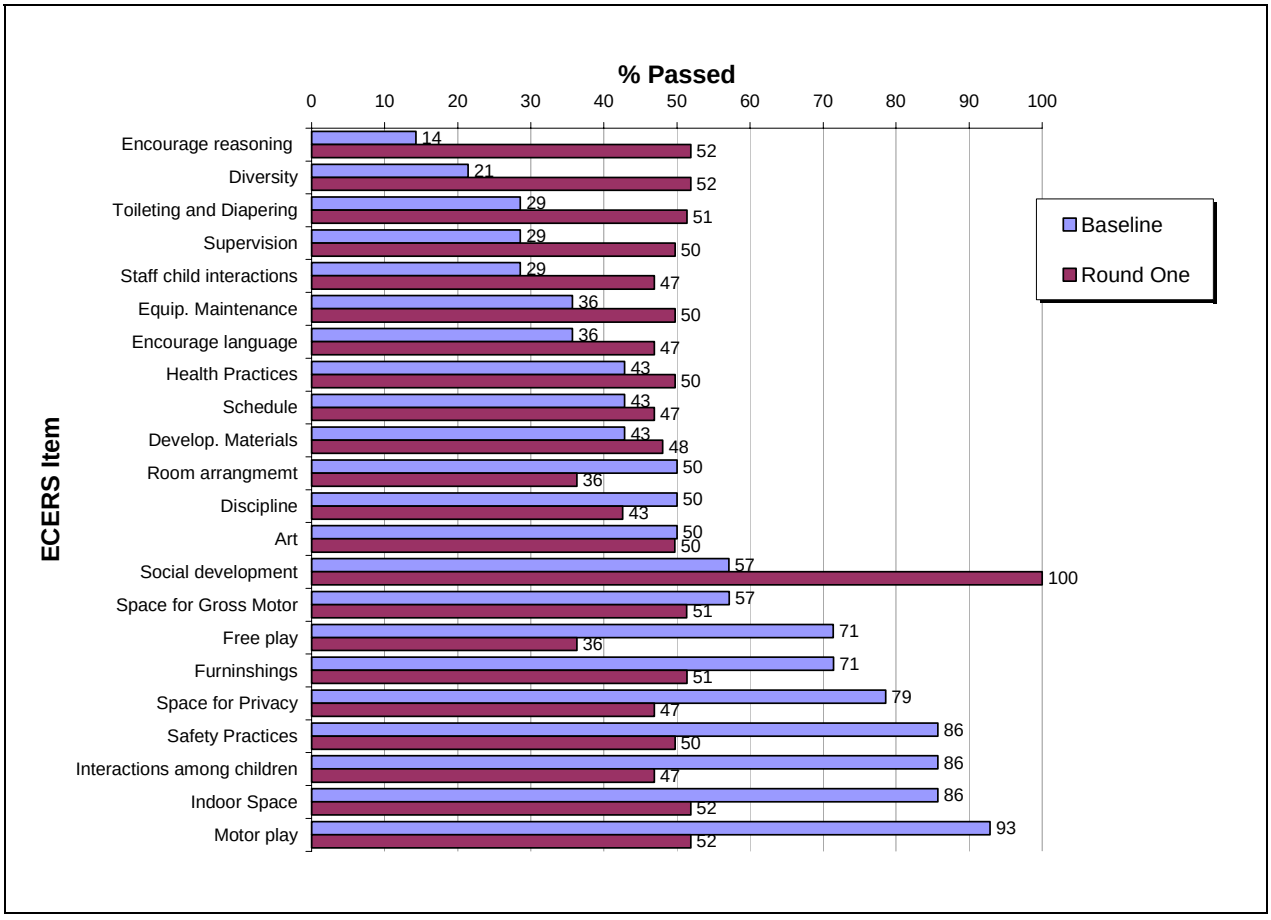
Child care centers, which were observed using the ECERS, showed improvement between baseline and Round One with respect to most categories of care included in the analysis. Improvements are particularly dramatic in social development, encouragement of reasoning skills, accommodation of diversity, basic care, supervision, and staff-child interactions. Toward the bottom of the chart, declines in "passing rates" may be noted with respect to room arrangement, free play, furnishings, space, safety, interactions among children, indoor space, and motor play. Centers scored relatively high at baseline in most of these categories, suggesting that the lower scores they achieved at the Round One follow-up may reflect a normal "regression to the mean" (i.e., a tendency of outstanding performance to level off in subsequent assessments). ECERS "passing rates" generally remain close to 50 percent or higher. Again, reviewing the item-level scores in Figure A.7 in Appendix A, it seems that most item scores are close to 5.0 or higher, with the lowest scores in the areas of safety and health procedures.

Figure 3.5
Family Child Care Homes Passing Rates at Baseline and at Round One Observation



* p<.05, ** p<.01

Figure 3.6
Centers Passing Rates at Baseline and at Round One Observation



Comparison Between Round One and Round Two Observations

During the period between the two rounds of observations, project services officially ended and programs were completing the final steps of the accreditation process. The majority of programs participating in both rounds of observations improved their global scores and most subscale scores over the course of the year, suggesting that improvements resulting from the project were sustained or enhanced during this six-to-nine month post-program period. As noted in the previous chapter, many programs did continue to receive some supports after the project ending date, and these undoubtedly contributed to the maintenance of quality. Figure

3.7 below shows that the combined ECERS/ITERS score average increased significantly between the two rounds of observation, while the average FDCRS scores remained approximately the same. BPA was able to compare sixteen child care centers and fifteen family child care homes across the two time points.

Figure 3.7
Comparison of Global Scores Round One and Round Two

	Round 1		Round 2		T
	Mean	Std Dev	Mean	Std Dev	
ECERS/ITERS (n=16)	5.48	.765	5.79	.808	-2.601*
FDCRS (n=15)	5.35	.810	5.36	.72	-.039

*p<.05

Figures 3.8, 3.9, and 3.10 below compare the samples' subscale averages across the two rounds of observations. Child care centers serving children older than two improved or maintained scores in all categories, while infant centers—which had scored extremely high in the first round, dropped slightly in the areas of space and furnishings, program structure, and relations with parents and staff. Scores for both groups of centers continued to improve in the areas of staff-child interactions and development of language and reasoning skills, which had already shown improvement between baseline and the first round of observation. In contrast, family child care homes' scores dropped slightly in the language and reasoning subscale, while improving or holding steady in other categories. However, FDCRS scores on this subscale had been extremely high in Round One—above 6.00—and the drop to 5.7 does not represent a significant decline in quality.

A promising finding is that for all three types of programs, the basic care/personal care category improved between the first and second observations. Nevertheless, this category, which includes safety and health procedures, continued to score lower than other subscales and was the only subscale score with an average below 5 on both the ECERS and FDCRS.

Figure 3.8
ECERS Subscales Round 1-Round 2 Comparison
(N=12 Child Care Centers)

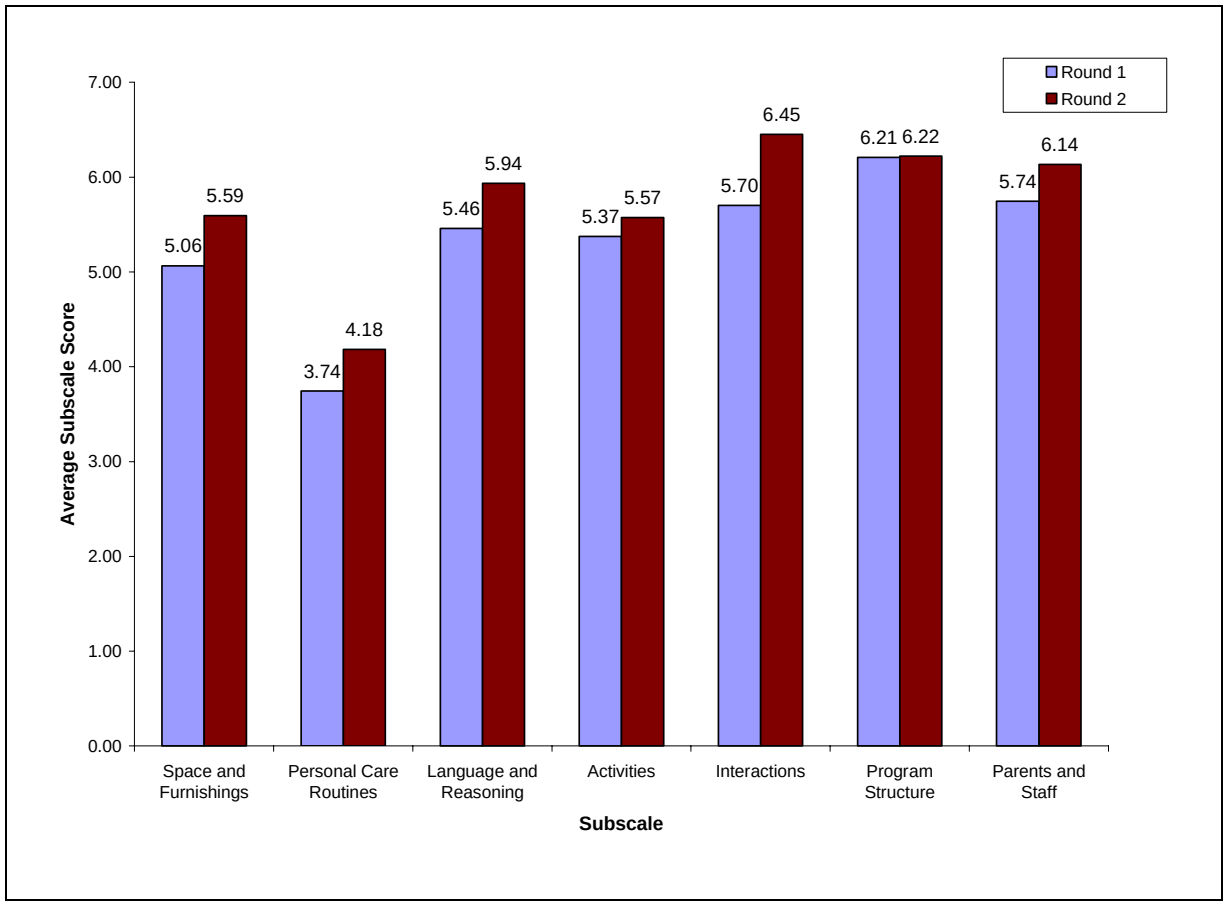


Figure 3.9
ITERS Subscales Round 1-Round 2 Comparison
(N=4 Child Care Centers Serving Infants)

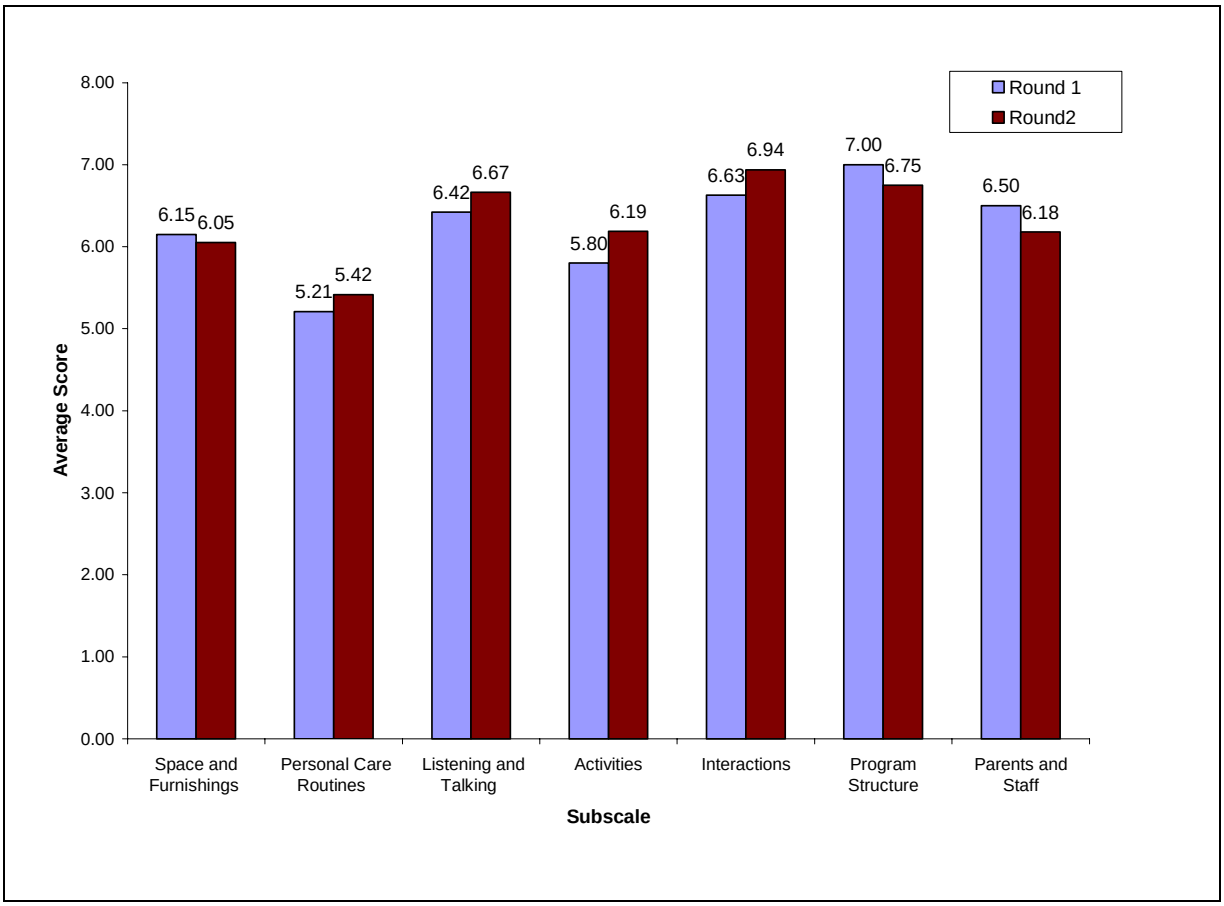
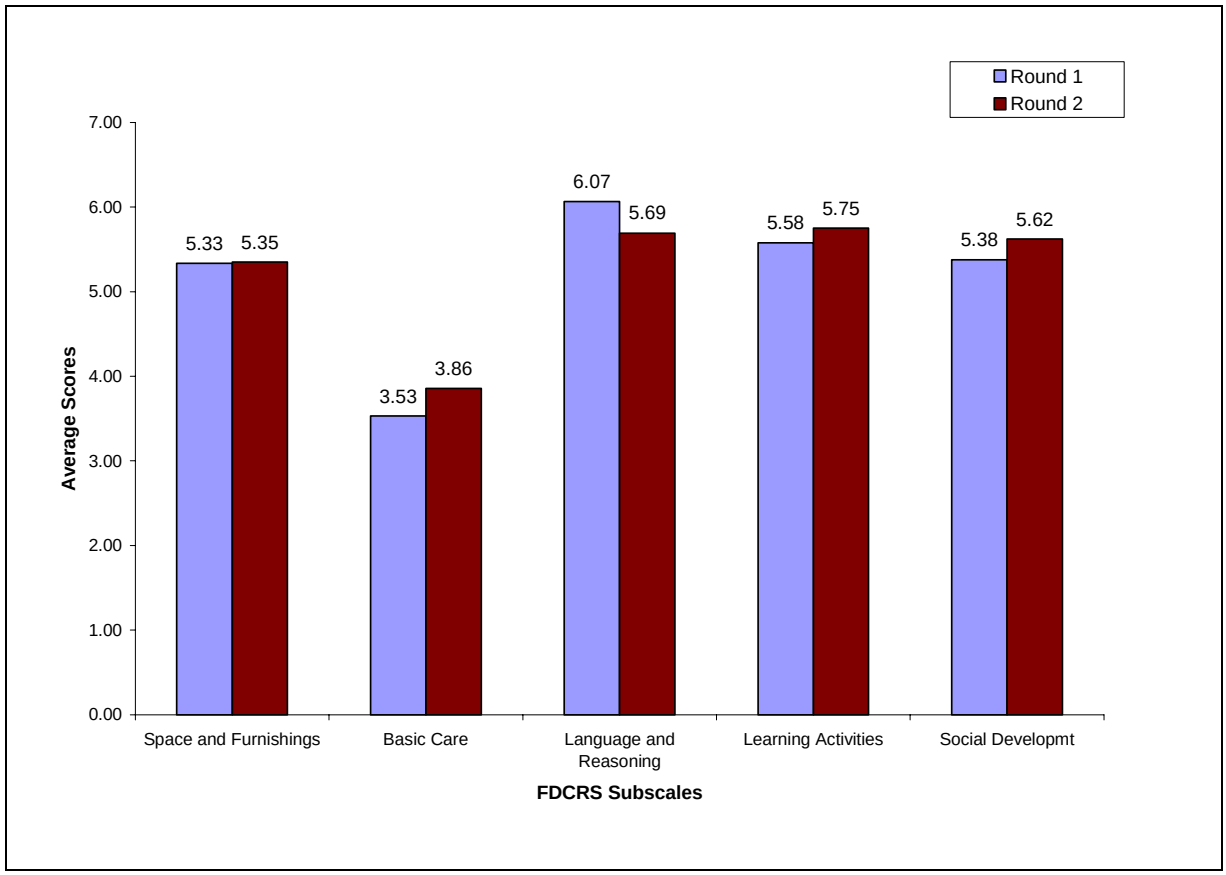


Figure 3.10
FDCRS Subscales: Round 1-Round 2 Comparison
(N=15 Child Care Homes)



Self-Report Data on Quality Outcomes

Interviews/Focus Groups

As part of site visits, evaluators asked focus group participants, as well as participants in observations, about enhancements implemented through the CDFAP. Family child care providers and center staff identified a number of common enhancements and benefits. (The most commonly identified enhancements are shown below in Figure 3.11.) Many credited the project with increasing their awareness of the importance of having multicultural items, and enhancement funds were used to purchase multicultural materials such as dolls and food.

Both center staff and family child care providers reported a positive impact on the variety of materials for play: puppets, costumes for dramatic play, math and science equipment, manipulatives (such as push and pull toys), water and sand tables, hammer toys, and bricks for building. Improvements were made in the classroom environment, including labeling, adding appropriate shelving, and generally making the materials more accessible to the children. Participants also worked to enhance the quality of their programs by establishing stronger relationships with parents. They added parent education components, discussed the accreditation process, established rules and requirements for parents, and held parent conferences.

Center staff reported that as a result of the project they changed their approach to lesson planning, becoming more thoughtful about the choice of activities. Family child care home providers reported a shift toward more educational programming. Many family providers made improvements in safety: tanbark for the backyard, improved swing sets, and securing windows and lighting. Family child care providers also focused on creating activity centers in their homes. Although limited by the amount of space in their homes, many providers were successful in creating defined play areas so that children of different ages could use different materials at the same time. Providers also reported that the project increased their awareness of health procedures, increasing hand washing and setting up appropriate diaper changing areas.

Figure 3.11
Enhancements Most Frequently Reported by Sample Programs

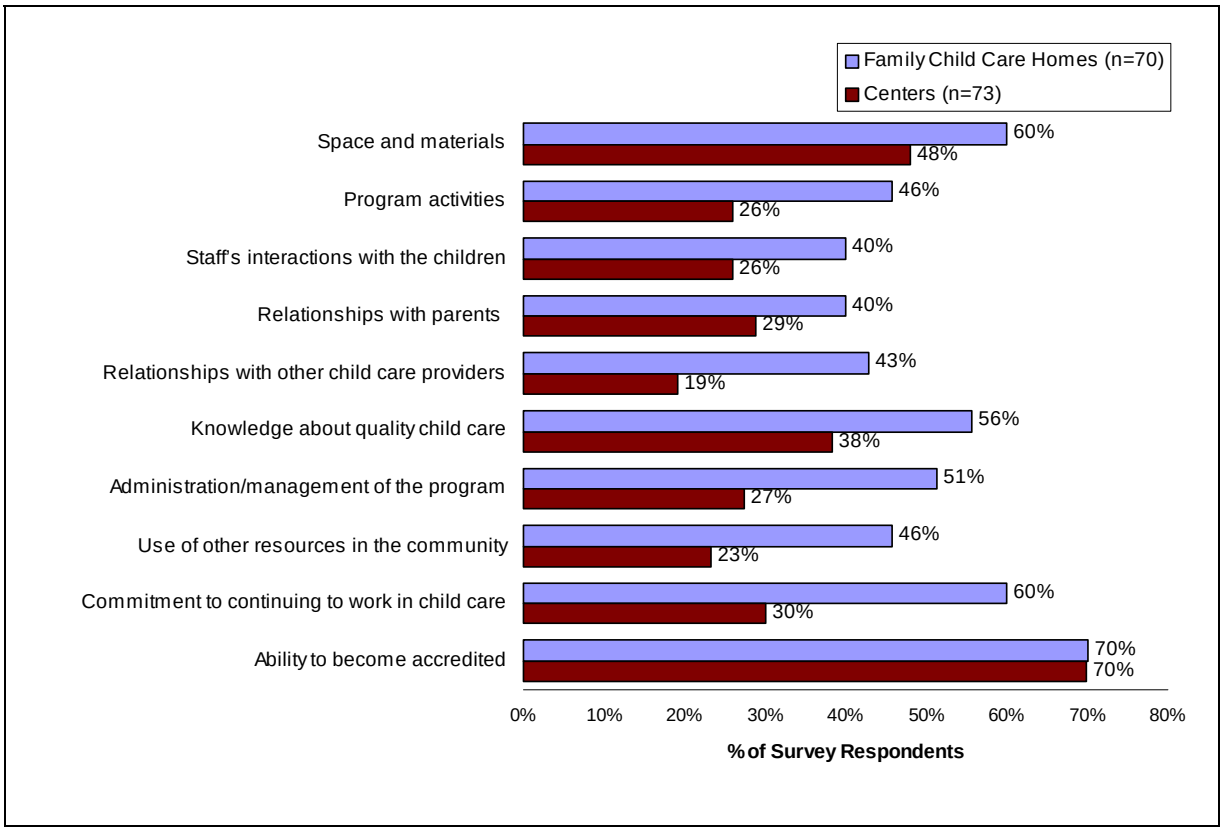
	Centers N=17	**Family Child Care Homes** N=25
Multicultural toys, materials	7	5
Dramatic play materials, spaces	8	3
Other classroom Equipment/Facilities	6	7
Safety (physical & health-related)	1	7
Curriculum	2	5
Stronger Relationships with Parents	3	3

Participant Survey

The survey asked participants to rate the CDFAP's contribution to various categories of program improvement. Figures A.10 and A.11 in Appendix A show that the majority of respondents (usually over 60 percent for both family child care homes and centers) indicated that each of the categories improved at least somewhat as a result of the project. Figure 3.12 below compares the proportions of respondents from centers and family child care homes that reported "a great deal" of improvement in each of the categories. Family child care providers were consistently more likely to credit the project with producing great improvements, perhaps because their baseline quality was lower, or because they had fewer non-project resources available to support quality than did centers. Among centers as well, key elements of quality care were often reported to be greatly affected: almost 40 percent of center respondents reported that staff knowledge of quality child care improved a great deal as a result of the project, half reported that space and materials improved a great deal, and almost 30 percent reported that staff-child interactions and program activities improved a great deal as a result of the CDFAP.

Beyond those areas having an immediate effect on program quality, respondents—especially family child care respondents—indicated that the project contributed to their longer term commitment to the field, their relationships with other professionals, and their ability to use resources in the community. These results suggest that the project contributed to the programs' capacity to continually improve.

Figure 3.12
Areas that Improved a Great Deal as a Result of the CDFAP
Based on Participant Survey Results



Conclusions about CDFAP Outcomes

Both the quantitative and qualitative data suggest that the programs that participated in the CDFAP were able to improve the quality of care through the services offered to them by the project, and were generally able to sustain or improve that quality six to nine months beyond the ending date of the project. While formal attribution of impact is beyond the scope of this project, the participants reported using project resources to improve various dimensions of program quality, and independent observations by the evaluators confirm that improvements were made. Quality improvements went beyond the enrichment of program materials and equipment that were paid for by the CDFAP enhancement grants; and were evidenced in staff-child interactions and stimulation of children's language and learning. With the

exception of some basic care/health routines in family child care homes, the quality of care offered by the participants was good, at a minimum, and sometimes excellent.

While our evidence indicates that family child care homes may have experienced more dramatic immediate benefits from the project, centers may be better able to sustain or build upon these benefits to make longer-term improvements. This is not surprising, since centers are more likely to have access to professional development and professional support networks than do family child care homes. The issue of sustaining support is further discussed in Chapter Five.

Chapter Four

Implementation of the Project

The following discussion of project implementation draws on interviews with key staff members of the project, including the project director, five regional managers, and twenty-three regional accreditation facilitators. These interviews were conducted in winter and spring of 2003. Additional data sources for the implementation study include partner interviews, participant focus groups held in four site visit counties, project reports and documents, and project staff presentations at advisory committee meetings.

Administration and Staffing of the Project

The CDFAP was a challenging undertaking that required the oversight and coordination of a highly dispersed staff to meet ambitious goals on a tight timetable. The timetable necessitated that the CAEYC rapidly put into place a statewide structure for recruiting, training, and bringing to the door of accreditation a very large number of programs and providers. Hiring of staff was substantially completed between contract award (late 2001) and January 2002. The CAEYC hired a project manager and five regional managers, including one lead regional manager, to be based in the CAEYC office in Sacramento. Each regional manager oversaw the work of four or five field-based accreditation facilitators, who worked from their homes to serve providers in up to three counties within the region. Facilitators were the direct point of contact between the participants and the project as a whole. The facilitators recruited participants, oriented and guided participants through the accreditation process, and organized training events.

Most regional managers and facilitators came to the project with substantial child development background. As part of project start-up, an introductory training session was held in Sacramento in January 2002. Staff continued to meet quarterly in Sacramento for project-wide meetings and training sessions.

The regional managers provided oversight and support to the facilitators in their different regions. Each regional manager traveled to his or her region monthly to hold in-person group meetings with facilitators. The monthly meetings provided the staff with opportunities to discuss project changes as well as project accomplishments and challenges. The regional managers acted as the main link between the facilitators dispersed throughout the state and the central CAEYC staff in Sacramento.

In-person meetings were supplemented with ongoing electronic and telephone communications. Most facilitators reported active mutual support among regional staff and frequent, informal, but highly productive exchanges of information. Most regional managers maintained at least weekly contact with facilitators via email or phone. Regional managers relayed messages from Sacramento regarding project policies and procedures, working to provide a uniform message to all of the facilitators in their region. The CDFAP created a project intranet, which enabled ongoing communication, as well as record keeping and reporting. Monthly electronic "chats" involved all staff via the intranet.

Nevertheless, the geographic dispersion of the staff, combined with the large scale and complexity of the project, created challenges. Development of new procedures necessarily involved trial and error and delay. Communication at times broke down, causing some facilitators to feel isolated and "out of the loop." When systems (for example, those involving purchasing and reimbursement) failed to work properly or efficiently, frustrations were exacerbated by remoteness. Facilitators also occasionally found that the project training they received did not fit the "realities" of the demanding caseload they faced in the field.

As it proceeded, the project also faced personnel turnover, inevitably resulting in disruptions. The project director and one regional manager were replaced in mid-2003, about six months prior to the ending date of the project. While most facilitators were retained throughout the project, occasional turnover occurred among facilitators (interview notes suggest that at least four facilitators left prior to the completion of the project). Shuffling of participants across facilitator caseloads caused stress among the participants as well as among the facilitators who might be asked to suddenly take on participants who were 'behind' in the process.

Recruitment/Retention

The initial wave of outreach and recruitment by the project was extremely successful in attracting widespread interest. The CDFAP staff cast a wide net to generate interest in the project statewide. They distributed a mass mailing to each of the 40,000 licensed family child care homes and 11,000 licensed centers in the state. The mailing included a flyer, explaining the project's offering of financial assistance and support for accreditation, along with an application of interest. Regional managers and facilitators conducted outreach through local child care associations, school districts, and colleges. CAEYC also consulted with CalSAC in identifying school age programs.

Facilitators' roles in recruitment varied, depending on the timing of their hiring and the specific circumstances of their regions. At least two thirds of the facilitators reported active involvement in recruitment. Many were well known in the local child care communities and were able to use contacts and partnerships from previous jobs to leverage their outreach efforts in their respective areas. Facilitators attended child care planning council meetings, local conferences, and city council and school board meetings to encourage participation in the project. Local resource and referral agencies sometimes assisted with outreach by distributing flyers. Several facilitators approached recruitment more selectively, using word of mouth to seek out programs and providers that clearly indicated readiness for accreditation. While the project's outreach met a very positive response in the state as a whole, resistance to accreditation was experienced in some counties, particularly rural counties. Facilitators in these areas made special efforts to explain the value of accreditation and obtain buy-in from school boards and other local leaders.

The CAEYC staff were initially inundated with inquiries. The project database shows that almost 3,000 family child care homes and 600 child care centers indicated at least preliminary interest in the project. A waiting list was created early on in the project to keep track of those programs that had expressed an interest but could not be accommodated immediately. Priority was given to programs meeting the service priorities of the project (serving children with special needs, with limited English skills, and infants). The project was successful in recruiting participants with the targeted characteristics, including many Spanish-speaking family child care providers.

All entrants were required to complete a screening phase and meet multiple criteria in order to continue participation in the project. The majority of early recruits did not complete the screening phase and were never officially selected, or enrolled, in the project. Many never completed the readiness form required as the first step in the screening process. Many family

child care providers did not qualify because they lacked a high school diploma (or GED), and some did not have a sufficient number of children enrolled (a minimum of three was required for accreditation). Centers were eligible only if they were state funded and if located in districts with low academic performance (based on the Academic Performance Index). All programs were required to have a license in good standing. Many programs did not meet these baseline requirements, and others recognized, as they learned more about accreditation and reviewed the readiness form, that they were not ready for the demands of accreditation.

The majority of participants were selected to join in March and April of 2002. However, due to continued attrition, a second wave of recruitment and enrollment took place between October and December of 2002. Many project staff continued to play an active role in recruitment throughout the project as attrition among participants threatened the project's ability to meet its goals. New enrollees continued to be brought onto the project, on an as-needed regional basis, as late as spring of 2003.

Challenges of Ongoing Participant Retention

Successful completion of the screening phase did not guarantee a smooth or easy path to accreditation. Perhaps the greatest challenge faced by the project was the retention of participants, particularly struggling family child care providers, for the "long haul" of accreditation. Below BPA presents the primary reasons for withdrawal from the project as recorded in the participant database. Interviews conducted by the BPA evaluation team elicited further explanation of the ongoing struggles that impeded participants' progress toward accreditation and often led to attrition.

Facilitators and participants alike noted in interviews that the economic downturn sharply reduced the demand for child care, and was especially hard on small family child care home providers. Some participants were forced to withdraw due to a drop in their enrollment. Among the family child care homes that dropped out of the project, many did so because they were closing their facilities or had too few children in their care to qualify for accreditation. State-funded centers were also affected by the economy: some faced loss of staff and/or administrative support, or potential closure due to cutbacks in state funding.

In some counties the project faced competition from other local quality improvement projects. While the CDFAP and other such projects often complemented each other, they also competed for providers' time and attention. Some local retention grants offered the providers a stipend that enabled providers to go back to school. Participants themselves were

overwhelmed and exhausted from providing child care during the day and attending professional development meetings in the evening.

Although the project database did not identify language barriers as a reason for withdrawal from the project, evaluators' interviews and focus groups suggested that language barriers were an ongoing problem that slowed many participants' progress and caused considerable attrition. While Spanish-speaking providers were aggressively recruited by the project, the limited availability of bilingual facilitators and of translation services impeded their full participation in the project. Translation services were needed during cohort meetings, during broadcast trainings, and during site visits/observations if the facilitator did not speak Spanish. Accreditation forms that were not translated also presented challenges, even for some providers with a good command of spoken English. Serious delays in the distribution of translated training materials produced considerable frustration for participants and are discussed later in this chapter.

An additional source of attrition among family child care providers was "life changes" that included career changes, funerals, weddings, family sickness, medical needs, and remodeling of homes. These personal events would impede progress and sometimes deter providers from continuing through the entire accreditation process. Approximately nine percent of family child care providers who left the project did so due to family or medical emergencies.

Sustaining participant motivation to complete the accreditation process was an unexpected challenge, according to many facilitators. Eighteen percent of family child care providers who withdrew from the project simply were no longer interested in pursuing accreditation status. Specific reasons for losing interest are not reported, but facilitator interviews and participant focus groups indicated that many providers were overwhelmed by the amount of work required to become accredited. Most family providers do not have additional support staff, and the accreditation paperwork and training requirements necessitated long hours beyond an already long workday. Facilitators also reported that some family child care providers became uncomfortable or intimidated by the continual scrutiny (by themselves and by outsiders) of their programs that was required as part of accreditation. Some providers participating in focus groups reported that the accreditation standards too demanding and seemed "to be trying to turn family child care homes into centers."

In contrast to family child care homes, centers have a relatively large number of staff members to assist with the accreditation process. However, the coordination and motivation of staff to work toward accreditation was challenging for center directors. Changes that a center director wanted to make in his or her facility needed to be communicated to the entire

staff. When staff turnover occurred, additional training was needed for newly hired staff. Motivating staff, both old and newly hired, to make these changes required time and effort. Implementing changes in staff-child interactions, for example, requires extensive training, commitment, and resources. Some center personnel became frustrated with the time required to implement changes, particularly when working under difficult circumstances.

Even in the face of these challenges, hundreds of programs and providers persevered in the process and completed the steps toward accreditation. The training and technical assistance offered by the project, and particularly the support and guidance of the facilitators, enabled committed providers and center staff to succeed. Specific strategies used by the project are described and evaluated below.

Project Data on Withdrawals

Figures 4.1 and 4.2 present the reasons identified in the project database for withdrawal from the project by the 677 programs designated as "dropped." As discussed above, the largest portion of family child care home withdrawals were attributed to loss of interest and to facility closure. Many programs dropped due to failure to meet eligibility requirements, which included possession of a high school diploma or GED, having a license in good standing (no violations reported within the previous two years), completion of sufficient training hours, and various requirements relating to support staff. Among centers, many withdrawals were attributed to "pending" or "waiting list" status; it is the evaluators' understanding that these categories include programs that expressed interest but were never enrolled either due to lack of openings, or to failure to adequately complete the initial paperwork. Most other center withdrawals were due to failure to meet project requirements, which for centers included location within a school district designated as low performing, funding through state subsidies, possession of a license in good standing, and completion of various project-related training requirements.

As noted in Chapter Two, approximately 1700 family child care homes were not explicitly coded as dropped, but appear in most cases to have failed to submit initial screening forms. Few data are available on these programs but evaluators believe these programs withdrew very early in the process due to the realization that they would not be eligible or would have difficulty completing the process.

Figure 4.1
Reasons for Withdrawal by Family Child Care Homes
(N=447)

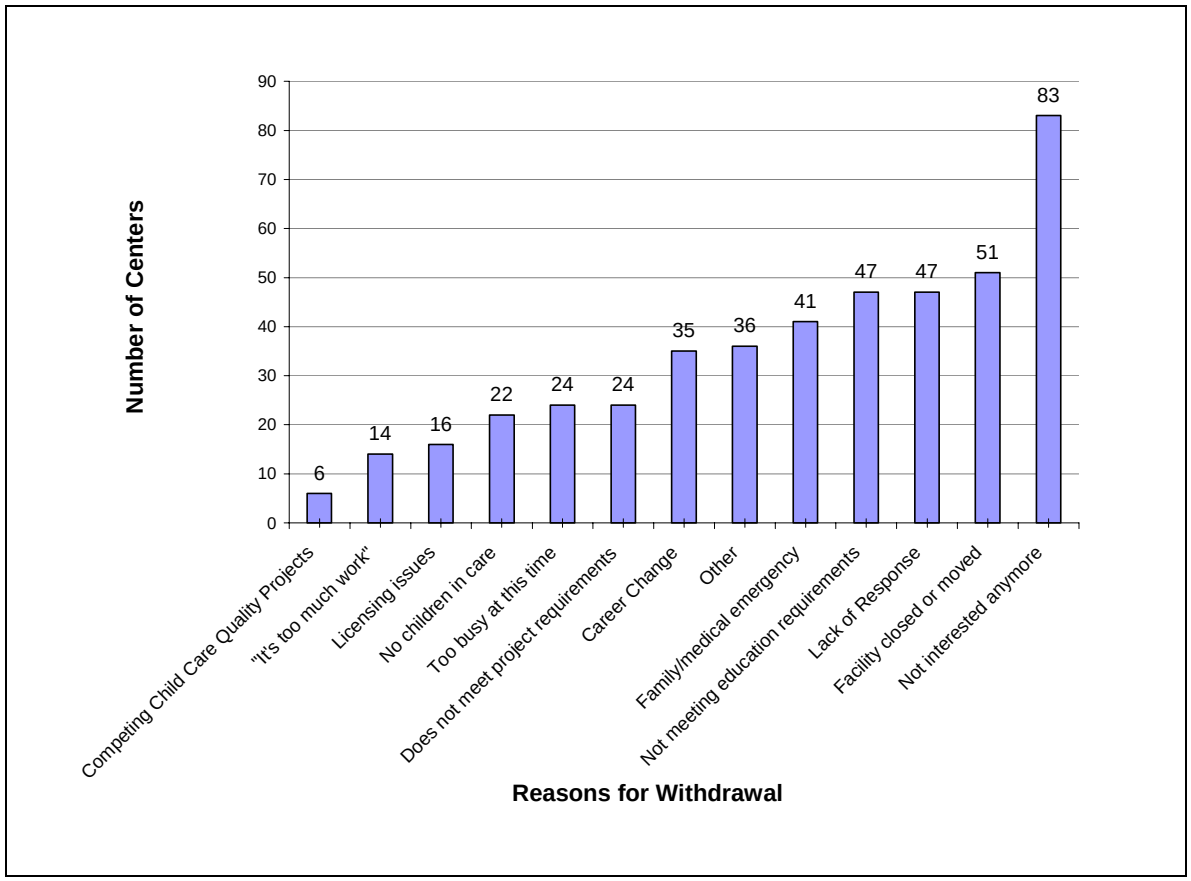
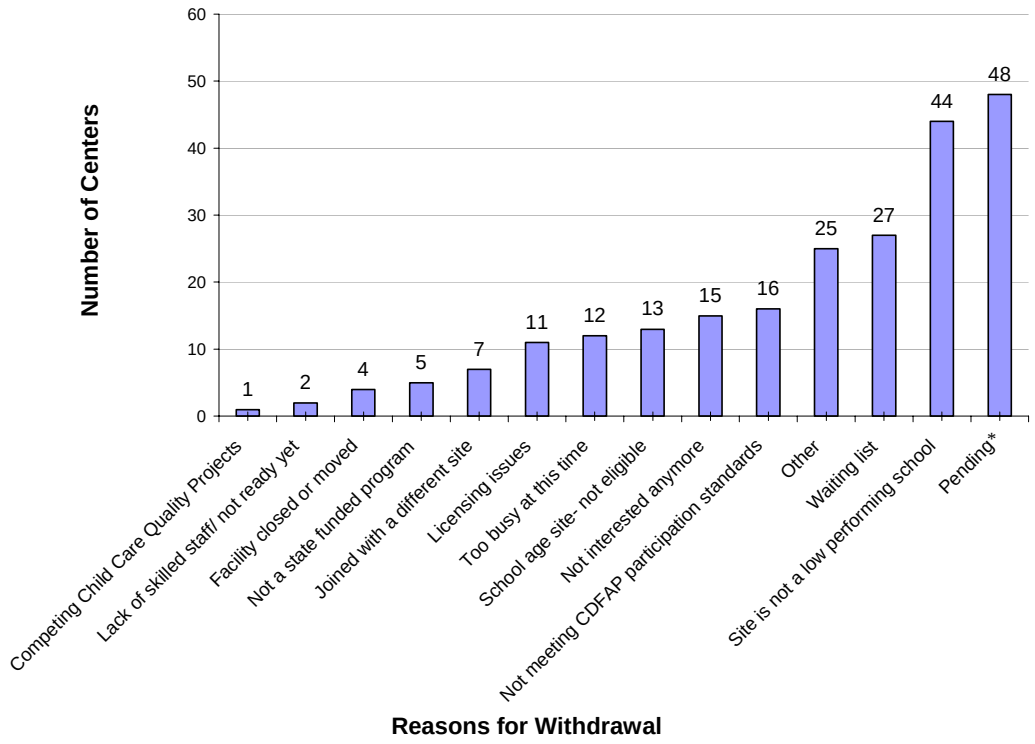


Figure 4.2
Reasons for Withdrawal by Centers
(N=230)



*Providers who did not complete initial paperwork.

Training Strategies

In an effort to assist providers with the accreditation process, CDFAP used a combination of training strategies. The three major strategies were: broadcast trainings (videoconferences); modules delivered by video or CD ROM; and county-based peer group trainings (called "cohort meetings"). Together these approaches offered the flexibility and variety needed by individuals, including the availability of self-paced training and other options to meet different learning styles. The technology-based training materials were designed by RISE, who drew on their extensive expertise in delivering child development training via the Internet and CD ROM to develop a series of broadcasts and corresponding modules. While they relied on their expertise in developing materials, RISE worked in close collaboration with CAEYC to ensure the quality and completeness of the content.

Broadcast Trainings. The first component of the training, broadcasts or videoconferences, served to bring together the accrediting bodies and local providers in order to impart information about the accreditation process. The videoconferences incorporated a question and answer period to address immediate concerns. Facilitators were responsible for securing training locations equipped with video satellite feeds, organizing the sessions, and assisting the participants with calling in to ask questions. A series of four live broadcasts was presented during 2002 at designated locations in each region. Videotapes were made available to participants who were unable to attend or who joined the project later.

The four broadcast topics included:

1) Accreditation readiness
2) Accreditation criteria
3) Preparation for self study
4) Preparation for observer/validator visit.

Feedback on Broadcasts. Of all the supports and trainings, the videoconferences were viewed by focus group participants as least effective. Participants gave mixed reviews, some finding the discussions interesting, while others were frustrated due to disconnected phone lines or bored with the repetitive content of the sessions. Many participants were limited to the taped versions, missing the opportunity for live discussion. Some facilitators were not able to access a live satellite broadcast. One facilitator, who was able to find the local resources to provide the live trainings to providers, did not feel supported by the project in learning how to go about accomplishing this.

Learning Modules. Another training tool was learning modules, which served to address in detail selected categories of standards for care and education. Based on the latest research, these modules came in two formats, interactive CD ROMs and video/workbook packages, and presented field-tested practices in accredited programs throughout California. They demonstrated intentional teaching and engaged the users in the learning process. Each provider or program was expected to view a series of modules and submit completed Activity Sheets and Reinforcing Concepts Sheets to CAEYC/CDFAP in order to receive a Certificate of Training hours.

RISE created sixteen learning modules on CD ROM or video to be used by participants as best fit their needs. The CD ROM was designed to be used interactively in conjunction with a website, while the video was accompanied by a workbook. It was the responsibility of the facilitators to work with each provider and program to select a series of modules that addressed the professional development needs of the particular program.

Feedback on Learning Modules. Feedback on the learning modules was also mixed. While some participants considered the modules to be a good training and reference tool or team-building exercise, actual use of this training tool seems to have been accompanied by many challenges among the participants. Many facilitators and participants (both family child care homes and centers) reported difficulty in using the CD ROM/Internet option because their computers lacked adequate capabilities and/or they found the software too advanced for their own skills. Ultimately, many facilitators and participants settled on use of the video/ workbook option, but only after considerable time was spent struggling with the CD ROMs. "This is a lost cause among my participants. It took forever to implement. It just doesn't work on my folks' computers." Participants using videos also needed some help from facilitators in completing the workbooks, and many commented that the whole process was overly time-consuming.

With respect to the content of the learning modules, many providers found the modules to be helpful in imparting new ideas for their own programs and in illustrating how to set up a classroom environment. However, some family child care providers reported they could not personally relate to the family child care homes displayed in the videos. The homes depicted in the videos, larger than the participants' homes and therefore better able to make some of the changes suggested in the video, did not present a realistic example of the typical provider's experience. These images could be discouraging for a population already coping with an overwhelming process. As to the content of the diversity-training module, several providers were disappointed and felt that the module did not capture the diversity of family childcare homes in California.

In addition, Spanish-speaking providers were disappointed in the long wait before receiving their materials, with only some of them receiving the materials in Spanish. While modules in English were delivered to facilitators in June of 2002, only the Diversity module was available in Spanish the following month. All other modules and workbooks in Spanish were delivered to facilitators in spring of 2003. Dissemination of those materials to the Spanish-speaking providers varied greatly. In addition, the website was not translated into Spanish; as a result, providers could not take advantage of the online services. Since all of the providers had to complete their paperwork at the same time, the delays placed the Spanish-speaking providers at a disadvantage.

Cohort Meetings. Each facilitator organized monthly cohort (peer support) meetings, bringing together family child care providers and centers—usually in separate cohort groups—to discuss issues of common concern. The cohort meetings did not have standardized topics for discussion, but were driven by the needs of the providers. The groups were designed to build long-lasting connections and mutual support among participants, and to offer an informational exchange among participants and between the facilitators and the participants. Topics for discussion might include child development topics, the dangers of Sudden Infant Death Syndrome, and other safety concerns, such as the use of car seats when transporting children. Some meetings addressed more project-related topics such as how to complete accreditation paperwork and what to expect from a validator/observer visit. At a family child care cohort meeting visited by evaluators late in the project, a provider who had recently received an NAFCC observer visit shared her experience of this visit with the other providers present.

Feedback on Cohort Meetings. Providers viewed these meetings as a good opportunity to share ideas, learn from each other, discuss subject matter of particular interest to them, and have specific questions answered by the facilitator. Some reported that the meetings enabled them to develop or strengthen a professional network that would outlast the project.

Some providers felt the meetings were too long, were held too often, and were scheduled at inconvenient times. Several participants had child care development classes in the evenings, and one particular participant had a time conflict because she provided child care on the weekends. One facilitator addressed time conflicts by providing two options for meeting times, which allowed for some flexibility on the part of the providers.

For those groups that were successful, many of the facilitators agreed that the format was very beneficial for the participants. Facilitators described how members of the cohort group

worked to provide support to each other as they walked through the steps towards accreditation. One facilitator told a story of cohort participants who donated toys to a member of the group who was struggling. As another facilitator said, "The [meetings] have served to create and build community; they allow the participants to check in, share resources, share ideas, and build relationships. They have been very well attended." Another facilitator offered the following words on the cohort groups: "The cohorts are a great place for child care providers to sit back and vent. It is also a time to network. It is also a great space for peer mentoring [because] there is no infrastructure for accreditation in this area once the CDFAP ends." The shared experience among the participants encouraged participation.

Facilitation

The facilitators were critical to the success of the project. The facilitator was the personal connection between the provider, CAEYC, and by extension, the national accrediting bodies. Facilitators were responsible for guiding participants through the accreditation process and ensuring that they were ready for accreditation by the project's end. The facilitators provided considerable individualized assistance to the participants, sometimes taking on the roles of mentor, problem solver, friend, and teacher. Facilitators were also responsible for organizing and coordinating training activities for participants within their service areas. These trainings included cohort meetings (described above) as well as occasional supplemental trainings designed collaboratively with local partners such as community colleges or First Five Commissions.

Each CDFAP facilitator worked with approximately fifty providers. Caseloads reflected the geography and demographics of the varying local areas in which the twenty-four facilitators worked. Facilitators in rural areas might serve providers as much as fifty miles apart, sometimes separated by mountain ranges. Facilitators in urban areas had caseloads concentrated within a radius of fifteen to twenty miles.

Most facilitators had caseloads of participants who spoke both English and Spanish, and most worked with both family child care homes and centers. Four facilitators worked exclusively with either Spanish- or English-speaking participants. Two individuals worked with family child care homes exclusively. Some facilitators worked with individuals whose primary languages included Mandarin, Farsi, and Russian. Facilitators worked with participants with widely varying backgrounds and levels of readiness for accreditation.

A primary responsibility of the facilitator was to work with each provider to develop and implement an Enhancement Summary Plan (ESP). The facilitator would conduct a baseline program observation, identifying unmet accreditation standards and steps to be taken to meet the standards. Steps included materials enhancements to be implemented through the project's enhancement grants; training tailored to the providers' and staff's needs; and continued program observation and feedback. The facilitators' job was to work cooperatively with participants, by phone and in person, to ensure mutual agreement on and comfort with the plan and to monitor progress in implementing it.

Facilitation Challenges

Many facilitators reported that their caseloads were too large, particularly given the extensive need for support among some participants, and the geographic distance among them. Working with such a large number of programs at one time required that facilitators work late hours, spend extensive time on the road, and make themselves available by phone late at night and over the weekends.

Facilitators were also called upon to meet the needs of participants with varied backgrounds. While some participants had been accredited before, others had only a few years of child care experience and little knowledge of quality standards. This diversity of experience and expertise made it challenging to design cohort meetings that were effective for all participants. Differences of culture, language, and work/family schedules also required accommodation.

Facilitators had concerns regarding confusing or burdensome administrative procedures and delays. A delay in the development of a purchasing form, for instance, created delays and confusion among participants. Both participants and facilitators reported lengthy waits for reimbursements. At several points procedures or forms were redesigned, leading to some confusion and to additional paperwork.

Facilitators' Strategies

Facilitators, using their own strengths as problem solvers, devised creative solutions to help the participants overcome barriers to accreditation. A major task for the facilitators was to build the participants' self confidence while also building the participants' trust in the CDFAP. Due to the private nature of running a child care facility out of one's home, many family child care providers were uncomfortable with visitors, associating them with the "policing" function that characterized licensing. Facilitators worked to develop a collegial

and supportive relationship with the participants. They served as advocates, mentors, and confidantes, empowering participants to gain control of the process. One facilitator commented: "I encouraged them to take the process one step at a time. It is like eating an elephant, you take one bite at a time." Another facilitator noted that participants were more confident if it was explained to them that the accreditation standards allowed for some flexibility: accreditation does not require that all standards be met, or that all be met in the same way. The facilitators realized how intimidating the process was for some of the providers and worked to allay their fears.

Facilitators developed a flexible approach in order to accommodate the participants' different needs. Some providers were relatively independent and required only occasional conversations with facilitators. Other providers required frequent contact. Most facilitators could not meet in person with each provider/program more than once or twice a month, but maintained frequent phone contact—up to three or four times per week—with providers who needed attention. In some counties, facilitators developed multiple cohort groups to accommodate the needs of Spanish-speaking providers, English-speaking providers, and centers. Depending on the geography and diversity of the service areas, facilitators might hold up to five different cohort group meetings each month. Facilitators experimented with different approaches to cohort groups, sometimes combining more experienced and less experienced providers so that the former could "mentor" the latter.

Some facilitators made special accommodations for participants, such as asking bilingual friends to attend meetings, asking bilingual family members to translate materials, and requesting some exceptions from the national accrediting bodies regarding Spanish-speaking participants. Two facilitators worked very hard to overcome the translation barriers by identifying translation services in the community and making them as available as possible to the CDFAP participants. Facilitators also reported that they learned to recognize and appreciate cultural differences in approaches to child care, and to support providers in maintaining their cultural style while addressing the accreditation standards.

Another key strategy used by many facilitators was to develop partnerships with local organizations to build support for accreditation, including support that will outlast the project. Partnership building and longer-term support for accreditation will be discussed later in this report.

Participant Reflections on Facilitators

Focus group participants emphasized the importance and value of the facilitator role. As one participant in a focus group revealed, "She has been our voice in this project. This has been one of the biggest strengths of the project." Facilitators provided good ideas, pinpointed specific needs to individual centers or homes, and provided choices for the providers on how to make improvements. Facilitators in the site visit counties were reportedly very accessible and available and willing to provide information on specific topics as the need arose. One participant mentioned that the facilitator had designed a class on child abuse reporting as a result of the identified need from providers. The need for more Spanish-speaking facilitators was the primary shortcoming noted by participants in this aspect of the project.

Financial Assistance

In order to offset the high cost of accreditation, the CDFAP offered the following forms of assistance:

- Payment of accreditation fee and membership in the accrediting organization, at a cost of $500-$1000 per program.

- Enhancement grants, linked to the purchase of materials or training opportunities specified in the Enhancement Summary Plan. For centers, grants of up to $5000 were available; for family child care homes, $500 was the maximum grant.

- Centers might also receive up to $1000 to cover the costs of professional development (including payment of substitutes staff) for three staff. Family child care homes would receive $100 upon completion of the required training hours.

These forms of financial assistance were critical to attracting participants into the project, and to ensuring that programs could successfully meet the accreditation standards. Most participants reported that they would never have been able to attain accreditation in the absence of these grants. The enhancement grants were used to make valuable improvements.

The CDFAP contract required that all of the 'material' money be spent by June 2003. This deadline created a purchasing crunch in spring of 2003. Facilitators learned that many participants struggled with how to fill out the order forms. As a result, some facilitators held 'purchasing parties,' inviting 15-20 participants to come together to decide how to best

purchase materials that would enable them to meet standards. Participants were able to give each other advice and feedback about specific materials. The facilitator was present to answer any questions they might have.

Family child care providers in focus groups expressed disappointment at how few enhancements they were able to purchase with the $500 allowance. Two facilitators, as well, told evaluators that the funding was simply insufficient to meet the enhancement needs of the family child care homes. Family child care providers often had fewer financial resources at their disposal than the centers and had fewer materials. Participants found they needed to spend additional monies of their own in order to be ready for accreditation. In some cases, participants could not afford to make the necessary changes and discontinued their participation.

Summary of Strengths and Weaknesses of Project Implementation

The project successfully implemented outreach and most services and supports as planned. Delays in providing translated materials and technical difficulties with computer-based training were the most significant shortfalls in implementation of the CDFAP's plan. The project was successful in recruiting programs that were diverse geographically, ethnically, and in level of child care experience, although the accreditation outcomes for the different subgroups are yet to be known. Based on BPA's findings to date, "low tech" elements of the project, such as facilitator support and cohort meetings, were more effective in serving participants than the "high tech" elements such as broadcasts and CD ROMs. This was due in part to the technological and design shortcomings of the high tech training, but it may be that for the population targeted by the project, personal contact was more critical than technology-based training, even if well-designed.

Personalized facilitation was especially important because sustaining participant motivation to pursue accreditation was a key challenge for the CDFAP. Participants valued the improvements in quality they were able to make through the project, but were not always convinced that the full process of accreditation was manageable or worthwhile. Many struggled to find the time to attend training events, to become familiar with all the accreditation standards, and to complete the paperwork. Support and encouragement from peers and facilitators were especially valuable for family child care providers, who were less likely than centers to have support staff or a well-established professional network.

Another key challenge that the project faced was in striking a balance between decentralized and centralized approaches to administrative systems. Meeting the project's ambitious statewide goals and timeline necessitated that locally-based staff, dispersed throughout the state, work in a coordinated fashion using many common procedures and approaches. The administrative structure of the project, in which local facilitators reported to regional managers who in turn reported to CAEYC administrators, was a rational one. Communication systems worked effectively most of the time. However, some facilitators found that the project could not respond flexibly enough to varying local needs.

Preliminary findings suggest that the project met most participants' expectations. Participants in interviews and focus groups reported that they were able to make the program improvements they had hoped for and to improve their own general knowledge of and commitment to quality care. Access to a peer support system and information exchange was an additional, unexpected benefit for many participants. The most notable client frustration was in the limited or delayed availability of translation services for Spanish-speaking providers, a high priority population for the project.

Chapter Five

Participant Feedback on the Project: Findings of the Statewide Survey

The CDFAP participant survey, in addition to providing those outcome measures described in Chapters Two and Three, produced data on participants' experience of the project and their perspectives on the usefulness of the various project services and supports. As described in Chapter Four, BPA collected preliminary feedback from participants through interviews and focus groups in the five site visit counties. The survey, based on a sample in which participants from almost every county were represented, enabled us to develop quantitative assessments of participant satisfaction and to present a more representative picture of participants' experiences statewide.

Participation in and Satisfaction with CDFAP Services

Figure 5.1 below presents survey results on utilization of project services, and Figure 5.2 compares center and family child care responses regarding the most helpful services. As shown in Figure 5.1, significant minorities of participants did not attend support groups or broadcast trainings; this result is not surprising, since interviews indicated that scheduling of these activities was often problematic. The finding that family child care providers were more likely than centers to participate in support groups is also consistent with site visit findings; facilitators intentionally placed greater emphasis on these meetings for family child care providers, in order to counter their relative isolation compared to centers (as manifested in their smaller staff, fewer professional development and networking opportunities). The evaluators do not know why some participants did not receive payment of accreditation fees, enhancement grants, or facilitator support, since all participants were expected to receive these services. As discussed in Chapter Four, delays or difficulties with paperwork processing, and facilitator turnover, might have been responsible. In the case of Spanish-speaking family child care providers, lack of translation services or limited numbers of Spanish-speaking facilitators might have interfered with their access to certain services.

Figure 5.1
Participants' Utilization of CDFAP Services

	Percent That did NOT Participate in or Receive This Service		
	Centers	All Family Child Care Homes	Spanish Speaking Family Child Care Homes
Broadcast Trainings	15.1	15.9	4.5
Help from the Facilitator	4.1	8.6	13.6
Monthly Support Groups	31.5	13.2	19.0
Payment of accreditation fees	17.6	13.2	28.6
Learning modules on CD ROMs/Videos	6.8	8.6	13.6
Grants for program enhancements	16.4	14.5	14.3

Figure 5.2 shows that the services most consistently appreciated by respondents of the statewide survey were the payment of accreditation fees and the enhancement grants. Three-quarters of respondents from centers and family child care homes alike reported that the waiver of accreditation fees—$500-$1000 per program—was very helpful. Centers and family child care homes responded similarly about grants for program enhancements. Seventy percent of respondents reported that the grants for program enhancements were very helpful. Centers were eligible for grants of up to $5000 and family child care homes for up to $500. These grants were often used to purchase materials that enabled programs to meet safety and health standards or enhanced the variety of multicultural materials available for children to use. (See Chapter Three for discussion of specific materials purchased by participants.)

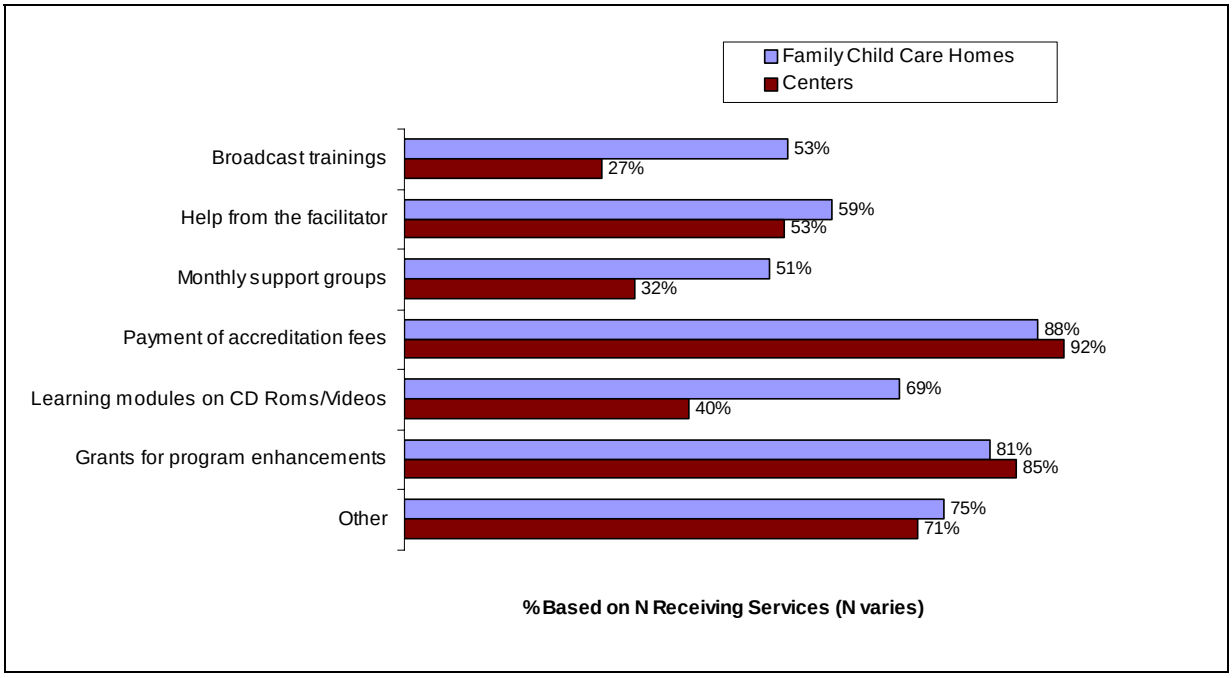
Overall, family child care respondents were more likely than centers to report the various training strategies as being very helpful. This difference may be explained by the fact that family child care homes typically have less access to professional development opportunities than do centers, and hence realized greater benefit from the CDFAP services. Almost half of family child care homes rated broadcast trainings as very helpful compared to about a quarter of centers. With respect to the monthly support groups, half of family child care respondents found them very helpful compared to about 30 percent of the centers. About two-thirds of family child care homes reported the learning modules to be very useful compared to 40 percent of centers. While focus group participants had voiced concerns about the technology

needed to access the CD ROMs, the survey results suggest that most participants were able to make good use of these materials through one of the modes available (learning modules could be accessed via video cassettes and workbooks as an alternative to CD ROMs/Internet).

Over half of both center and family child care respondents rated facilitators as very helpful. One family child care provider elaborated: "My facilitator . . .was the best teacher and helper that a person could have. She gave all of her extra time and effort to make sure that all my questions were answered, and help was given when needed."

Respondents also commented on additional CDFAP services or resources that benefited the quality of care in their programs. Items described by family child care providers included a class on creative curriculum, newsletters, and books. Centers identified music CDs, materials such as books, lesson plans, laminated pictures of families, and the workshops arranged by CDFAP. As discussed in Chapter Three, focus group participants reported substantial benefits from curricular and safety materials purchased through enhancement grants.

Figure 5.2
CDFAP Services Rated by Participants as Very Helpful



Barriers to Success

The survey asked participants to rate the degree to which various factors created barriers to successful participation in the project and/or completion of steps towards accreditation. Respondents rated potential barriers using a four-point scale ranging from "not at all a barrier" to "major barrier." Figures 5.3 and 5.4 present the full range of family child care and center responses to these questions. As the figures demonstrate, most participants reported few major barriers, although many reported minor barriers related to staff motivation, burdensome paperwork, and delays in enhancement grants.

Figure 5.3
Barriers Identified by Centers
(N=74)

Please check the box that best indicates how much each of the factors listed was a barrier to your successful participation in the Accreditation Project and/or completion of steps towards accreditation:	Not at all a Barrier	Minor Barrier	Moderate Barrier	Major Barrier
The trainings/broadcasts were not offered at a convenient time	70.3	23	2.7	4.1
Language barriers (materials were not translated into my primary language or facilitator did not speak my primary language)	87.8	6.8	4.1	1.4
Insufficient time to go through the accreditation process	75.7	13.5	10.8	0
Inadequate support from CDFAP facilitator	62.2	20.3	8.1	9.5
The enhancement grants were delayed	75.7	20.3	4.1	0
It was difficult to motivate staff	60.8	29.7	6.8	2.7
The paperwork was burdensome	32.4	39.2	12.2	16.2
It was difficult to meet the requirement for training hours	66.2	24.3	6.8	2.7
It was difficult to meet accreditation standards	68.9	24.3	6.8	0

Figure 5.4
Barriers Identified by Family Child Care Homes
(N=67)

Please check the box that best indicates how much each of the factors listed was a barrier to your successful participation in the Accreditation Project and/or completion of steps towards accreditation:	Not at all a Barrier	Minor Barrier	Moderate Barrier	Major Barrier
The trainings/broadcasts were not offered at a convenient time	72.7	12.1	4.5	10.6
Language barriers (materials were not translated into my primary language or facilitator did not speak my primary language)	88.1	10.4	0	1.5
Insufficient time to go through the accreditation process	79.1	10.4	4.5	6
Inadequate support from CDFAP facilitator	76.1	7.5	9	7.5
The enhancement grants were delayed	77.6	13.4	6	3
It was difficult to motivate staff	52.9	27.9	8.8	10.3
The paperwork was burdensome	52.9	29.4	14.7	2.9
It was difficult to meet the requirement for training hours	73.5	14.7	11.8	0
It was difficult to meet accreditation standards	80.6	6	9	4.5

Figure 5.5 compares center and family child care responses regarding barriers to successful completion rated as either moderate or major. As the figure illustrates, the most severe barrier for family child care homes was personal life challenges, followed closely by burdensome paperwork. Because family child care providers operate programs in their own homes, personal life challenges can be particularly demanding and disruptive. (As noted in Chapter Two, personal life challenges were often responsible for withdrawal from the project.) For center staff, barriers most frequently noted were burdensome paperwork and inadequate support from the CDFAP facilitators. In interviews and focus groups, center and family child care home participants alike had discussed their frustration with the amount of time and effort spent on forms related to the project and to the accreditation process. While most survey

respondents rated facilitators as very helpful (see Figure 5.2), and focus group participants had overwhelmingly praised facilitators, the survey also reveals that facilitators were not consistently effective statewide. Given their large caseloads, the geographic dispersion of caseloads in some counties, and the wide range of participant needs facilitators were asked to accommodate, it is not surprising that some facilitators were not sufficiently available to their clients. Because of the critical role of the facilitator, shortcomings in their performance or helpfulness could be devastating to participants struggling to complete the accreditation process.

Figure 5.5
Moderate/Major Barriers Reported by Homes and Centers

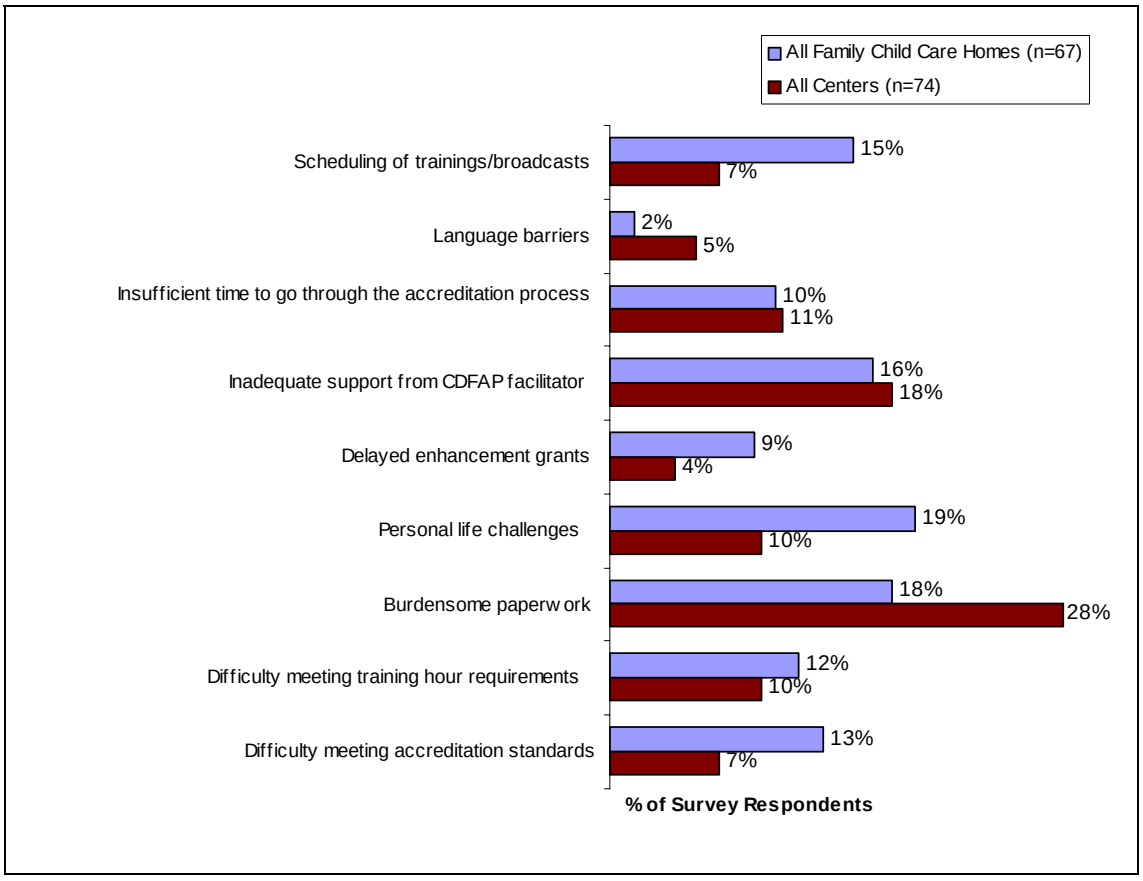
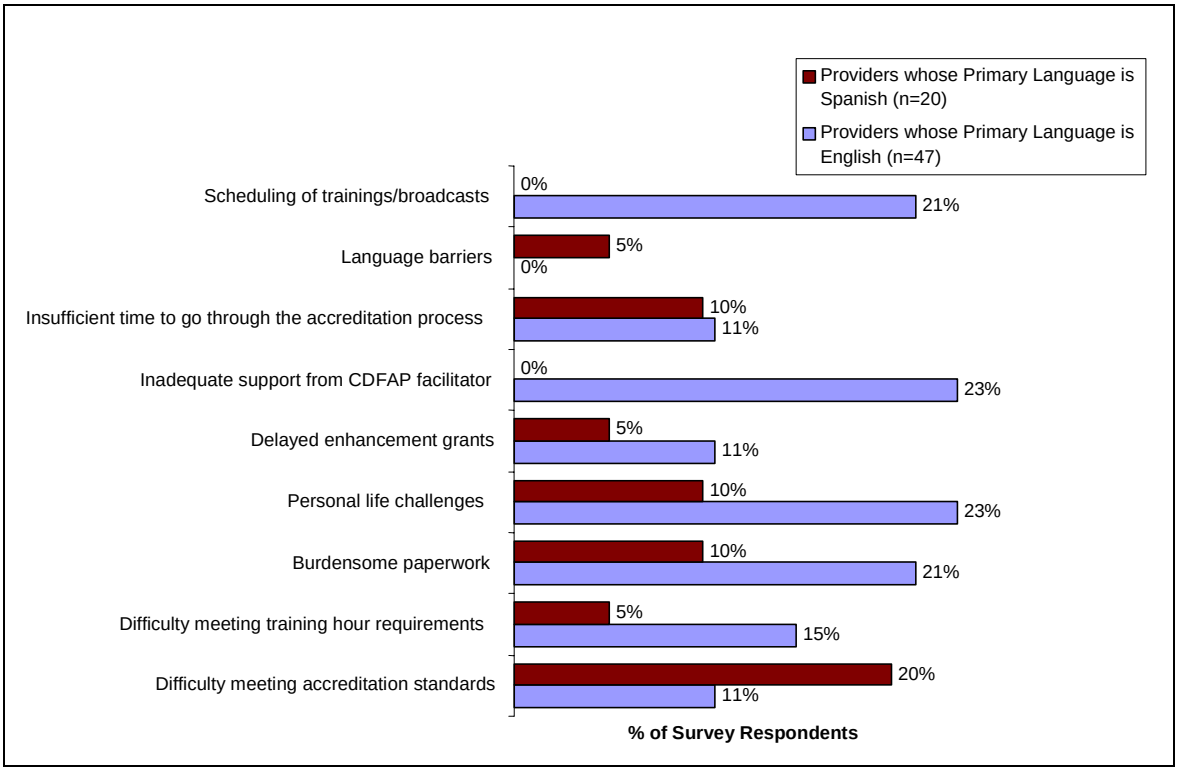


Figure 5.6 presents a comparison of moderate and major barriers identified by English-speaking and Spanish speaking family child care providers. While some Spanish-speaking providers did consider language barriers to be major, the proportion of those who did was relatively small considering the problems and delays with translated materials discussed in the previous chapter. These results may testify to Spanish-speaking providers' perseverance in the process and to the hard work of Spanish-speaking CDFAP facilitators. It is noteworthy that no Spanish-speaking family child care providers identified inadequate support from facilitators as a moderate or major barrier, while almost a quarter of English-speaking providers did. Another barrier more likely to be rated as serious by Spanish-speaking than English-speaking providers was difficulty meeting accreditation standards. Spanish-speaking providers were less likely to emphasize personal life challenges and burdensome paperwork and were about equally likely to identify insufficient time to go through the process.

Figure 5.6
Moderate/Major Barriers Reported by Spanish-Speaking and English-Speaking Family Child Care Providers



Survey respondents were also asked to write comments to elaborate on factors they found had hindered their successful participation in CDFAP and/or completion of steps towards accreditation. Figure 5.7 displays the barriers reported by the respondents and the number of times those barriers were mentioned by both family child care homes and centers.

Figure 5.7
Comments on Barriers to Success in the CDFAP*

Family Child Care Homes	Centers
Facilitator support (10)	Facilitator support (10)
Lengthy wait for validation visits (8)	Lengthy wait for validation visits (8)
Burdensome paperwork (4)	Training hours (7)
Personal life challenges (4)	Burdensome paperwork (4)
Accreditation standards (3)	Accreditation standards (4)
Language barriers (2)	Language barriers (3)
Broadcast trainings (2)	Broadcast trainings (3)
Difficulty in getting materials (1)	Staff turnover/part-year staff (3)
No copier equipment (1)	Staff motivation (2)
CDFAP project ending (1)	Concerns about fees/renewal (1)
Concerns about fees/renewal (4)	

*Narrative responses on statewide survey

Twenty center and family child care home survey respondents cited concerns about the availability, frequency of follow-up, basic communication, accuracy of information, and turnover of their facilitators. For example, one family child care provider commented that "the facilitator was unavailable to answer questions," while another noted a gap of three months before a new facilitator was hired to replace one who had left her position. Both family child care providers and center directors commented on difficulties with the scheduling and time demands of CDFAP training activities. One family child care provider noted conflicts between CDFAP training meetings and other classes in which she and other providers were enrolled. A center director suggested that, "it would have been easier to check out the tapes as our own group," instead of attempting to view the live broadcasts. As discussed in Chapter Two, lengthy waits for validator or observer visits were another concern for many programs.

A few respondents from both centers and family child care homes commented on language barriers. Centers' comments suggested that centers, as well as family child care providers, had a need for translated materials for parents and staff that the CDFAP may not have anticipated. One center director commented, "The paperwork for the modules was not in Spanish and that added to the burden of having to translate." Several Spanish-speaking family child care providers also expressed concern that very few Spanish-speaking project staff were available.

Several center and family child care home survey participants also elaborated on the difficulty of accomplishing the changes necessary to meet the accreditation standards, finding that the financial and personal support offered through the project was insufficient to enable them to meet the standards within the time required. Respondents cited multiple barriers that emerged in trying to meet the standards such as "finding time for staff to meet and discuss" and "duplication of and unclear standards, multiple standards thrown into one paragraph." One center noted that it would have been beneficial to visit other centers to see how they met various criteria and accreditation standards.

Three center respondents described special staffing/scheduling circumstances that impeded their success in meeting accreditation standards. One director noted that the program's reliance on substitute teachers in the summer time was a barrier that affected the quality of care during that time of the year. Another program located on a college campus utilizes student aides. Another director noted competing demands for staff time needed to meet required state standards such as Desired Results.[10]

Post-Project Support

The time-limited scope of the CDFAP, supporting participants only to the "door" of accreditation rather than through the final steps of the accreditation process, presented problems for some survey respondents. When commenting on barriers to success, several respondents expressed frustration that their facilitator and/or main contact did not respond or provide additional support after the CDFAP ended. As one provider put it, "It's kind of like being baptized and then the congregation leaves; who answers the questions? The support/structure is gone."

[10] Desired Results is a comprehensive system of program standards and child-based performance measures that has been gradually introduced throughout all state-subsidized programs in California beginning in 2001.

At least one center and four family child care respondents expressed concern about their longer-term ability, not only to become accredited, but to remain accredited. They commented that renewal, required in three years in order to remain accredited, would entail prohibitive fees. "I wish that another grant/stipend would become available when my accreditation expires. The fee is prohibitive and I have heard many others say that they will simply have to let it lapse."

Many facilitators did attempt to build longer-term sources of support for project participants. As noted in Chapter Three, some participants developed a greater commitment to the child care field as well as greater access to local resources, as a result of the project. Figure 5.8 presents responses to survey questions about ongoing support and professional development beyond the life of the project.

Figure 5.8
Post-Project Support

	Percent of Respondents Reporting Activities After Completion of CDFAP (December 2003)	
	Centers (n=67)	Family Child Care Homes (n=70)
Taken classes or attended conferences related to child development/child care	85	83
Received any support specifically designed to help you become accredited or remain accredited	32	30
Continued to share information with providers you met through the CDFAP	36	61

Four out of every five center and family child care home survey respondents reported that they continue to take classes and attend conferences related to child development and child care from a number of institutions. The CAEYC was the most frequent source of training for centers. Other sources of ongoing training included various local agencies, community colleges, and universities. The majority of family child care home providers received training provided by local child care chapters and associations, as well as community colleges and universities. Local resource and referral agencies appear to play a notable role as well. The following table provides further details of professional development sources for family child care home and center staff.

Figure 5.6
Institutions Providing Training/Professional Development to CDFAP Participants After Project Completion

Family Child Care Homes	Centers
Local child care chapters/associations (34) College/university (19) Local resource & referral agencies (7) Junior or community colleges (4) Childcare conferences (4) YMCA (3) Assn. for the Education of Young Children (3) Program for Infant/Toddler Caregivers (3) Local Office of Education (3) County First Five Commissions (2) Children's Homes Society (2) WestEd (2)	Assn. for the Education of Young Children (16) Various local non-profits, etc. (16) In-house training (6) Junior/community colleges (5) College/university (5) Conferences (4) Early Childhood Education Div. (3) Local education orgs. (school district, department of education, county) (3) Local Planning Councils (2) Head Start (1) County First Five Commissions (1)

About one-third of both family child care home and center respondents reported that they received support specifically designed to help them become and remain accredited. Centers reported that this support was provided by individuals associated with accreditation or child care organizations, former facilitators, or by their own programs. Family child care providers reported receiving similar support through a variety of individuals including other already accredited providers. Figure 5.7 provides further details of the sources of additional support to become or remain accredited for family child care homes and centers.

Figure 5.7
Organizations/individuals Providing Additional Support for Accreditation

Family Child Care Homes	Centers
Other individuals (6) Classes/Conferences (6) Providers already accredited (4) Grants (2) Magazines/educational items (1)	Professional related to accreditation or child education organization (5) Other individuals (4) Former CDFAP facilitators (3) Own program/company (3) Videos or classroom materials (3)

As discussed earlier, one of the objectives of the CDFAP was to create a sustainable peer support group among providers in each county who met through the project's monthly cohort group meetings. Since the end of the project in December 2003, one-third of the center respondents and two-thirds of the family child care home respondents continue to have contact and share information with colleagues met through the project. Figure 5.8 below presents details on this continuation of contact.

Figure 5.8
Continuing Contact Between Providers Met Through CDFAP

Family Child Care Homes	Centers
Monthly (12)	Monthly (9)
Quarterly (11)	Quarterly (4)
Infrequently (9)	Every other month (3)
Ongoing/regular (7)	Often (3)
Weekly (4)	Did not describe frequency (5)

Participants' Recommendations

Many participants indicated in their comments that they found the project very valuable, but would have liked to see it extended or refined in a number of ways. Below BPA summarizes survey respondents' recommendations for improvements to this or similar projects that might be considered for the future.

Recommendations related specifically to the Child Development Facility Accreditation Project included:

- Translate all materials completely into Spanish. Many Spanish-speaking providers did not have access to materials in their native language, which they needed. Some centers found they needed to devote staff time to translating materials, which was a drain on resources.

- Hire and retain facilitators who are highly committed to the project and to the development of young children. Some providers had difficulty making the most of program resources because they found their facilitators to be inaccessible or unreliable.

- Continue at least some elements of the project for a longer period of time. If funds are not available to sustain facilitator positions, consider sustaining training components, grants for materials, and on-line services. Respondents asserted that if an accreditation level of care is to be continued there should be "more incentives along the path to renewal": grants, materials, and supplies. The financial expense of renewing can be prohibitive for smaller programs.

Recommendations related to accreditation and accreditation systems more generally included:

- Offer more promotion and recognition of the value of an accredited program to the public. Providers felt that the public was not aware of accreditation, of the stringent standards that providers must meet, and the benefits to child development. "There needs to be recognition."

- Provide more publicity from Resource and Referral agencies for programs that are accredited. Providers recommended that these agencies highlight accredited programs for parents seeking childcare and provide publicity on those programs.

- Place the accreditation application on-line. Though forms may be downloaded from the NAFCC website, many providers expressed frustration at having documents lost. An on-line form would be one way to retain information provided by a program.

- Make more up-to-date information on accredited programs available on the NAFCC website. Providers that had used the site for additional guidance indicated that they would have liked to access a list of accredited providers in their area, with the opportunity to contact them and use them as resources.

- Provide more validator participation in the accreditation process. Providers going through the accreditation process for the first time often have questions about standards and how they are (or should be) making adjustments to their program to meet those standards. Having access to or contact with a validator in advance of the visit would be another way in which to provide needed technical assistance to programs.

Chapter Six

Conclusions

Summary of Findings

The Child Development Facility Accreditation Project was a pioneering effort to increase the number and diversity of accredited child care programs throughout California. The project had approximately two years to staff and implement a statewide system for outreach and services to over 1200 programs, and to bring these programs to the door of accreditation. The demands on the project to rapidly devise and implement new systems and achieve ambitious results were likened by one staff member to the process of "flying a plane while building it." Evaluation findings suggest that the project substantially met its targets for bringing programs to the door of accreditation and also contributed to improvement in many dimensions of child care quality. The project also succeeded in creating child care provider support systems and public awareness of child care accreditation in communities where they did not previously exist.

The following is a summary of the key evaluation findings presented throughout this report:

- The project succeeded in bringing about 340 subsidized child care centers, 740 family child care homes, and 20 school-age centers to the door of accreditation: these programs had submitted all or almost all accreditation paperwork by the project ending date and expected to complete the accreditation process. About one-third of the family child care providers had a primary language of Spanish and most family child care homes served infants, as did about 16 percent of the centers.

- Large numbers of the programs recruited in the early stages of the project, including over 2000 family child care homes and 200 centers, either never officially enrolled in the project or withdrew at some point during the process. Major reasons included failure to meet eligibility requirements, loss of interest, competing demands for time,

and insufficient capacity in the CDFAP project itself that resulted in waiting lists for participation.

- Survey findings based on reports of a statewide sample of participants about nine months post-project found that 9 percent of centers, 39 percent of family child care homes, and 54 percent of school-age centers had been officially accredited so far. These differences among the program groups reflected differences in the capacity of the three accreditation systems to accommodate a surge in the numbers of applicants. Few survey participants had been denied accreditation, but most awaited scheduling of accreditation validator visits, or awaited official decisions after visits had been conducted. All or most programs expected to become accredited, but lengthy waits resulted in frustration and some additional work.

- Quality improvements resulting from the project were significant, according to the combined results of program observations, the participant survey, interviews, and focus groups. Improvements in staff-child interactions, children's social development, program materials and activities, and some areas of basic care, were realized by many participating programs and were sustained or enhanced for six months after project completion. Participants also reported that the project strengthened their networks with other professionals and their commitment to the child care field.

- Among the various services and supports offered by the project, participants reported the payment of accreditation fees and enhancement grants to be the most helpful, but most found the training and facilitation services to be helpful as well. Family child care providers were more likely than centers to participate in monthly support groups organized by the project, probably because they were less likely than centers to have other opportunities for professional networking. Family child care providers were also more likely than centers to rate the project's training resources as very helpful.

- Among the barriers to success that caused the most concern for survey respondents were the demands of extensive paperwork, conflicts caused by personal life challenges, and inconsistent availability of project facilitators. Needs for more translated materials were noted by both family child care providers and centers.

- Survey results suggest the project enhanced the capacity of participating programs to continually improve. More than six months after expiration of the CDFAP grant, most survey respondents (over 80 percent) reported continuing participation in

professional development activities; about one-third reported receiving continued support for accreditation either through their own programs or through various individuals or local agencies; and over 60 percent of family child care providers and 30 percent of centers reported continuing contacts with professionals they had met through the project.

- Participants found the project very valuable, but expressed concerns about their ability to maintain their program quality over the long term without additional grants for training and materials, and about their ability to sustain/renew their accreditation status in the future without additional waivers of accreditation fees.

The Value and Role of Accreditation

To understand the systems context for the project and the possibilities for ongoing support for accreditation, the BPA evaluators interviewed representatives of various child care organizations. These included statewide partners as well as local agencies in the site visit counties. Representatives of Resource and Referral Agencies, First Five Commissions, and Local Child Care Planning Councils were interviewed, as recommended by local facilitators. The interviews focused on the coordination and integration of accreditation and accreditation projects with other statewide and local approaches to supporting child care and improving its quality.

The following are key findings and suggestions emerging from these interviews:

- The community/cultural context and "readiness" for accreditation varies widely across the state. In some counties, stakeholders reported a serious need to address "basic" child care deficiencies in areas such as safety, health, and group size before directing substantial resources to accreditation.

- Some experts suggested the formation of "pre-accreditation" support/training groups for providers who are not yet ready for the accreditation process but who have an interest in raising standards and in perhaps entering the accreditation process within a year or two. These support groups would provide a more gradual introduction to accreditation standards and support providers in meeting the standards over a longer time frame.

- The CDFAP was widely praised for "spreading the word" about accreditation and high quality standards, but was also criticized by several stakeholders for spreading resources too thin—for emphasizing "breadth rather than depth." Some suggested that accreditation projects should use much smaller facilitator caseloads, no larger than ten to fifteen, with more intensive support and a longer period of follow-up.

- In some localities, multiple quality approaches and initiatives compete for providers' time and attention. For example, the "Retention Incentives Project," funded through the California Children and Families Commission, provides stipends in many counties for child care providers who enroll in classes to obtain a credential. This is a somewhat different approach than accreditation. The latter focuses on the program rather than the individual providers, and although both approaches improve quality, the time demands and training priorities can be at odds with one another.

- Conflicts with accreditation might result from upcoming implementation of statewide standards such as Desired Results, which requires subsidized centers to put in place a comprehensive child assessment system. While the underlying goals and standards are not incompatible with those of accreditation, child care practitioners might become overwhelmed by multiple demands that are not coordinated. Since accreditation is not (yet) a state requirement, programs are likely to prioritize their time in favor of other standards that must be me in order to maintain funding.

- Employers might have an interest in supporting accreditation of programs used by their employees, and the possibility of obtaining employer financial support for accreditation is being explored in some communities.

- Some counties (through First Five Commissions or Offices of Education) do intend to provide ongoing support for accreditation efforts, and in at least a few cases efforts are specifically targeted to support former CDFAP participants who have not yet become accredited. Evaluators were not able to obtain a statewide overview of the number of these local support activities.

- Parent awareness of child care quality issues and the meaning/value of accreditation also varies greatly across the state. However, most stakeholders observed little parent pressure for programs to become accredited. Some raised the question of whether incentives really exist for most programs to become accredited,

and suggested that accreditation will become more widespread only when the state integrates accreditation into requirements for state funding.

Evaluators took up the issue of incentives for accreditation by including a question on the participant survey about the benefits of accreditation. This question was addressed to programs that had already been accredited, and, unfortunately, only five child care centers and 25 homes were in this position at the time of the survey. Some of them had been too recently accredited to determine whether benefits resulted, but about 40 percent of both groups believed that accreditation led to better professional development opportunities, and 40 percent of the relevant family child care providers observed that accreditation did lead to more parent interest and to reduced staff turnover. Other benefits described by centers were "increased credibility," "show of solidarity with the field," and serving "as a model to our students and community." Family child care providers who were accredited noted the opportunity to "be more of a mentor," "to validate/improve my program," "pride," and "new energy and motivation to do our best."

Figure 6.1
Benefits of Accreditation Identified by Recently Accredited CDFAP Participants

		Yes (%)	No (%)	Too soon to tell (%)
Family Child Care Homes (n=25)	Advertising benefits /more parents interested	40	40	20
	More professional development opportunities	44	40	12
	Reduced turnover of staff	36.8	57.9	5.3
	Other	46.7	46.7	6.7
Centers (n=5)	Advertising benefits /more parents interested	20	20	60
	More professional development opportunities	40	20	40
	Reduced turnover of staff	0	60	40
	Other	50	0	50

Lessons and Recommendations

Below are key lessons learned to date through the project's experience, and recommendations for future child care quality improvement projects that emerge from these lessons.

Regional and local differences should dictate differing approaches to accreditation and quality improvement. Regional facilitators working for the CDFAP faced widely varying contexts for accreditation. In many urban counties, accreditation was already well known and understood. A challenge facing the project in some of these areas was competition for providers'/programs' time and attention from various other quality improvement and professional development initiatives. In rural areas, facilitators were more likely to face lack of knowledge about, or resistance to, accreditation, as well as much lower levels of experience in the child care community. These differences in outlook, along with variations in local culture, geography, and resources, required different strategies from facilitators and also had differing implications for the level of support and time needed by participants to achieve accreditation. Project facilitators were able to use their local knowledge as well as their professional expertise to respond to these different needs. However, for future projects, several recommendations emerged:

- Accreditation goals, timeframes, targets, and caseload sizes should reflect regional and local differences.
- Central administrators should visit local areas and observe local conditions in order to better understand the challenges faced by facilitators (or other local project staff).
- It is important to maintain active two-way communication between site staff and central administrators, and also among facilitators, participants, and accrediting organizations.

Increased public education about child care quality and public recognition of accredited programs is greatly needed. In some communities, facilitator outreach to educate the public about quality standards was necessary for successful recruitment. The increased public awareness and support for accreditation that resulted in these communities, and throughout the state, were significant benefits of the project. Placing accreditation on the public "radar screen" raised the bar for child care quality, introducing the attainment of comprehensive quality standards as a goal to be sought, even if not to be accomplished immediately. Where quality levels have been generally low, participation in the project had benefits even for programs that may not achieve accreditation immediately. Nevertheless, continued public education—of parents and community leaders as well as child care providers—is needed.

Among specific suggestions from project participants and stakeholders were: resource and referral agencies should identify accredited programs on lists given to parents, larger media-based public information campaigns should be undertaken, and websites should be made available to the public that explain accreditation and post names of accredited programs.

Recruitment and outreach materials should make clear the level of commitment required to complete accreditation. While the project's screening process was clearly designed to ensure participant readiness, participants' expectations in some cases remained unrealistic. The evaluation team did not review outreach and orientation materials and cannot comment directly on these. However, some participants did not seem to have been fully informed from the outset about the comprehensiveness of the standards and the number of steps, including paperwork, that the process would entail. Because attrition and turnover are so costly and discouraging for staff, it is important to help potential participants fully understand these details before making the decision to enroll. Participants who are not ready for accreditation should be offered or referred to other quality improvement projects.

Family child care homes need more support than centers in order to achieve accreditation. As noted throughout this report, individualized facilitation and support were most crucial for family child care providers, who face numerous material and psychological barriers to successful completion of accreditation. The project provided significant benefits for family child care providers, but many providers continued to face barriers. In order to learn from and improve upon the experience of the CDFAP, future projects should consider the following:

- Because of the differing expertise required, some facilitators should specialize in family child care homes and others in centers.
- Facilitators should work with small groups of providers and maintain regular, frequent contact.
- Translators and translated materials should be readily available.
- A larger enhancement grant, at least $1000, should be considered for family child care homes.
- Family child care staff/assistants should be included in trainings.
- Relevant college courses should count toward fulfillment of project training hours.

The waiting period for accreditation should be shortened, and support should be continued until accreditation is officially awarded. Accreditation outreach projects should take into consideration the capacity of the accreditation system to accommodate new applicants without a lengthy wait. New participants should be phased in gradually as the system becomes ready to make validators available and to issue accreditation decisions. Long waits are discouraging to participants and may necessitate additional paperwork. Future projects should be designed to maintain facilitator support throughout the full accreditation process, so that facilitators can help participants prepare for validator visits and implement validator recommendations for program improvements. Programs already accredited should be tapped as part of the support network for accreditation applicants in their localities.

Accreditation is a valuable element of a quality child care/preschool system, and funding incentives for accreditation should be integrated into preschool initiatives. In many states, including California, tiered reimbursement policies are under consideration, sometimes as part of proposals for universal preschool programs. Tiered reimbursement would establish the highest (or one of the highest) reimbursement levels for accredited child care programs. The current ongoing accreditation reinvention process may cause some confusion in the short term but will ultimately strengthen the accreditation systems. A combination of state-level financial incentives and various localized, well-designed accreditation support projects would ensure an appropriate place for accreditation as part of larger efforts towards universal preschool of high quality.

Appendix A

Baseline Data

and

Additional Tables on Program Improvement

Baseline Data

Baseline Data

The CDFAP staff provided evaluators with a baseline database on the sampled programs. This database identified, for each program, specific accreditation standards not met (or not fully met) by the program as determined by the facilitator during a baseline observation. Baseline observations of these programs were conducted in the second half of 2002.

Figure A.1 below presents the NAFCC accreditation standards most frequently identified in the CDFAP database as not met or not fully met at baseline by the sampled family child care homes. Figure A.2 presents the standards most frequently not met by the full universe of CDFAP family child care homes, as reported by the CDFAP staff in December 2003. The sample's unmet standards appear to closely parallel those of the universe of family child care participants, with science and math materials, dramatic play materials, and materials reflecting diversity high on both lists.

Figure A.1
Evaluation Sample:
NAFCC Standards Most Frequently Not Met at Baseline
(N= 42)

Standard		No. Homes
2.43	Science materials	20
5.20	Monthly evacuation drills	15
2.44	Dramatic play materials	13
2.42	Math materials	12
2.16	Preschoolers' equipment for motor development	11
2.31	Materials reflect racial/ethnic diversity	11
2.32	Materials show diversity of age/gender roles	11
6.19	Written policies for parents	11
2.15	Toddlers' equipment for motor development	10
2.45	Specific list of tools	10

Figure A-2
All CDFAP Participants:
NAFCC Standards Most Frequently Not Met at Baseline

Standard		No. Homes
2.43	Science materials	641
2.32	Materials show diversity of age/gender roles	591
2.31	Materials reflect racial/ethnic diversity	551
2.44	Dramatic play materials	550
2.16	Preschoolers' equipment for motor development	466
2.15	Toddlers' equipment for motor development	431
2.42	Math materials	427
2.45	Specific list of tools	377
5.20	Monthly evacuation drills	347
2.36	Language materials such as puppets, written materials in home language, interactive games	332

As Figures A.3 and A-4 below show, baseline shortcomings of the centers in the sample were also representative of those of the universe of centers participating in the CDFAP. Encouragement of reasoning skills, following hand washing procedures, and availability of materials reflecting diversity are among the frequently unmet standards on both lists.

Figure A.3
Evaluation Sample:
NAEYC Standards Most Frequently Not Met at Baseline
(N=17 centers)

Standard		No. Centers
B-7c	Encourage children to think, reason, question, and experiment	13
A-3a	Teachers speak with children in a friendly, positive, courteous manner	11
B-5a	Materials project diverse attributes	11
H-14b	Staff follow proper handwashing procedures	11
H-15a	Space & equipment well-maintained	11
A-8	Teachers support children's emotional development	10
B-5d	Developmentally appropriate equipment for preschoolers	10
B-7e	Enhance physical development, skills	10
B-7h	Respect cultural diversity	10

Figure A.4
All CDFAP Centers
NAEYC Standards Most Frequently Not Met at Baseline
(N = 350 centers)

Standard		No. Centers
B-5a	Materials project diverse attributes	253
B-5d	Developmentally appropriate equipment for preschoolers	228
B-7c	Encourage children to think, reason, question, and experiment	215
B-7h	Respect cultural diversity	209
B-7d	Encourage language and literacy development	204
G-4	Variety of age-appropriate materials, equipment	197
G-7	Soft furniture and toys	186
H-14b	Staff follow proper handwashing procedures	178
H-15a	Space & equipment well-maintained	178
H-20a	Dangerous products labeled and locked, inaccessible to children	178

Source: Child Development Facility Accreditation Project, California Association for the Education of Young Children, 12/7/03.

Comparison of NAFCC Standards and the FDCRS

In conducting the partial crosswalk of NAFCC standards with the FDCRS, we focused on standards not met in accreditation categories 2 through 5:

2: The Environment
3: Activities
4: Developmental learning goals
5: Safety and health

As Figure A.5 below shows, in most cases, a cluster of specific NAFCC standards corresponds to a single FDCRS item. For example, standards 2.10, 2.11, and 2.12, concern the need for children's individual storage space, and furnishings for children's play and learning activities, both of which are addressed in FDCRS item 1, Furnishings for Routine Care and Learning. In a few cases, multiple FDCRS items correspond to a construct represented by a cluster of standards. For example, FDCRS items 2, 4, and 6 as a group convey the goals for comfortable furnishings and adequacy of space and space arrangement that are embodied by NAFCC standards 2.5, 2.6, 2.9, and 2.20. Standards that address materials for motor development are spread among six FDCRS items and twelve NAFCC standards not met at baseline. In a few cases, NAFCC standards were too

specific to be clearly aligned with FDCRS item(s); for example, we excluded standard 2.45 from the analysis because it lists a set of tools that are not identified with the same degree of specificity anywhere in the FDCRS.

Overall, indicators of quality embodied in the two measures are well aligned. For example, the FDCRS includes one item, #29, on Cultural Awareness, while the NAFCC standards include multiple standards on cultural awareness spread throughout categories 2 and 4. However, the indicators included in FDCRS #29 directly address most of the components of cultural awareness embodied in the NFCC standards. Among the requirements for a "good" FDCRS score are "Many examples of racial variety in dolls, pictures, and books" and "Holidays and cultural customs of all children in group included" and "Boys and girls encouraged to choose activities without being limited to traditional roles." Similarly, NAFCC standard 2.31 states that "Materials reflect the lives of the children enrolled and people diverse in race and ethnicity" and 4.18 states that "The provider introduces cultural activities based on the authentic experiences of individuals rather than a 'tourist curriculum' of exotic holidays and stereotyped decorations." Standard 4.16 (not included in our crosswalk because it was not identified as unmet at baseline in any of the sampled programs) states that "The provider assures that children and their families are not stereotyped or left out of any activity because of their race, gender, ethnicity, disability, or any other personal characteristics. Girls and boys have equal opportunities to take part in all activities and use all materials."

Figure A.5
NAFCC Standards Not Met at Baseline and Corresponding FDCRS Items

Category	FDCRS Item	NAFCC Standards Not Fully Met at Baseline (Parts 2, 3, 4, and 5)
Furnishings for Routines	1	2.10, 2.11, 2.12
Indoor Space Arrangement/	2, 4, 6	2.5, 2.6, 2.9, 2.20
Materials for Large/Small Motor Development	16, 18-21,23	2.3, 2.14, 2.15, 2.16, 2.17, 2.26, 2.27, 2.28, 2.29, 2.30, 2.36, 4.25,
Safety	13	2.23, 2.25, 5.5, 5.12, 5.13, 5.14, 5.17, 5.18, 5.20, 5.21, 5.22, 5.23, 5.27, 5.30, 5.37, 5.39, 5.43, 5.44, 5.45, 5.46, 5.47, 5.50, 5.54, 5.55, 5.67, 5.74, 5.75
Discipline	28	3.25, 3.26, 3.30, 4.3
Meals/Snacks	8	4.13, 5.85, 5.86, 5.87, 5.88, 5.93, 5.94
Music	20	4.47, 4.48, 4.49
Dramatic Play	22	2.32, 2.44, 4.50
Art	19	2.40, 2.41, 4.42, 4.43, 4.44
Health	12	5.77, 5.97, 5.98
Cultural Awareness	29	2.31, 4.18
Tone	27	4.2, 4.19
Language Development	14a, 14b,15a, 15b,16	2.33, 2.34, 2.35, 2.36, 2.37, 3.20, 3.6, 3.9, 4.37, 4.38, 4.9
Helping Children Reason	17	2.42, 2.43, 4.39, 4.41
Nap	9	5.63, 5.64, 5.103,
Space for Gross Motor Play	5	2.7, 2.18, 4.18, 4.24
Schedule	25	3.13
Diapering/Toileting	10	3.21, 3.22, 5.6, 5.56, 5.57, 5.58, 5.60, 5.61
Child Related Display	3	4.46
Supervision	26	5.1
Use of TV	24	3.33, 3.34

Comparison of the NAEYC Standards and the ECERS

Using the criteria discussed above, we focused on the following accreditation categories for crosswalking with the ECERS:

A. Interactions among teachers and children
B. Curriculum
G. Physical environment
H. Health and safety.

As Figure A.6 shows, we again found a high degree of compatibility between the accreditation standards and the environmental rating scale, despite differences in the organization of indicators across categories. For example, the ECERS items of General Supervision and Staff-Child Interactions are scored based on indicators that are similar or identical to those of the NAEYC standards listed below, including: affectionate and respectful interactions; availability of staff for sympathy and help; and age-appropriate encouragement of independence and self-control. Multiple ECERS items focus on the encouragement of language and literacy using principles consonant with those in the NAEYC standards: these include availability of a print-rich environment, encouragement of conversation during both free play and group activities, and encouragement of both receptive and expressive language activities. Health and safety indicators in both systems include strict hand washing procedures for staff and children, planning and provision for emergencies, and maintenance of records.

Figure A.6
NAEYC Standards Not Met at Baseline and Corresponding ECERS Items

ECERS Category	ECERS Number	NAEYC Standards Not Met at Baseline
Indoor space	1	G-1a, H-18a
Furnishings for relaxation	3	G-7
Room arrangement for play	4	G-3
Space for privacy	5	G-6
Space for gross motor play	7	G-9a, H-19a
Toileting/diapering	12	H-13a, H-14a, H-14b, H-14c, H17c,
Health practices	13	B-7f, H-2a, H-14a, H-18b, H-18c,
Safety practices	14	H-19b, H-20a
Use of TV, video, computers	27	B-6a, B-6b
Acceptance of Diversity	28	A-4a, A-4b, B-5a, I-3, B-7h
General Supervision	30	A-3a, A-5, A-10, A-2, A-2, A-3b,
Discipline	31	A-6a, A-6b
Staff-child interactions	32	A-1, B-7a, A-8
Interactions among children	33	A-9
Schedule	34	B-4c, B-4e, B-9, B-10, B-11,
Free play	35	B-8
Provisions for children w/disability	37	B-2b, B3b,
Maintenance of equipment	1, 8	H-15a
Encourage language-literacy	15, 16, 17, 18	B-7d,
Encourage, thinking, reasoning	17, 25, 26	B-7c
Art, music	20, 21	B-7g
Social development	33, 36	B-7b
Gross motor play	7,8	B-7e
Level appropriate materials	8, 19, 20, 21, 22, 23, 24, 25, 26	B-5d, B-5e, B-5f

Figure A.7
ECERS Item Scores
(Round One Observations)

ECERS Item	Average Score Round 1 (N=13)	Average Score Round 2 (N=12)
1. Indoor space	4.23	5.42
2. Furniture for routine care, play and learning	6.00	5.75
3. Furnishings for relaxation and comfort	4.85	5.33
4. Room arrangement for play	6.46	6.50
5. Space for privacy	4.31	5.33
6. Child-related display	4.85	5.75
7. Space for gross motor play	4.69	5.50
8. Gross motor equipment	4.77	5.17
9. Greeting/departing	4.58	6.30
10. Meals/snacks	4.00	3.33
11. Nap/rest	2.56	2.88
12. Toileting/diapering	3.54	2.83
13. Health practices	3.69	5.25
14. Safety practices	3.15	4.00
15. Books and pictures	5.08	5.50
16. Encouraging children to communicate	6.31	6.58
17. Using language to develop reasoning skills	4.62	5.08
18. Informal use of language	5.38	6.58
19. Fine motor	5.46	5.17
20. Art	5.69	5.92

Figure A.7 *(continued)*
ECERS Item Scores (Round One Observations)

ECERS Item	Average Score Round 1 (N=13)	Average Score Round 2 (N=12)
21. Music/movement	4.92	4.55
22. Blocks	6.23	5.58
23. Sand/water	5.38	6.08
24. Dramatic play	5.62	5.67
25. Nature/science	4.08	5.33
26. Math/number	5.15	5.58
27. Use of TV, video, and/or computers	4.5	5.33
28. Promoting acceptance of diversity	5.38	6.08
29. Supervision of gross motor activities	5.00	6.08
30. General supervision of children (other than gross motor)	5.23	6.83
31. Discipline	5.62	6.25
32. Staff-child interactions	5.92	6.92
33. Interactions among children	5.77	6.17
34. Schedule	5.77	5.42
35. Free play	6.15	6.25
36. Group time	6.62	6.75
37. Provisions for children with disabilities	5.60	6.67
38. Provisions for parents	6.46	6.33
39. Provisions for personal needs of staff	5.08	5.92
40. Provisions for professional needs of staff	5.23	5.58
41. Staff interaction and cooperation	6.36	6.64
42. Supervision and evaluation of staff	6.23	6.25
43. Opportunities for professional growth	5.00	6.17

Figure A.8
FDCRS Item Scores
(Round One Observations)

FDCRS Item	Average Score Round 1 (N=25)	Average Score Round 2 (N=15+C22)
1. Furniture for routine care and learning	5.64	6.60
2. Furnishings for relaxation and comfort	5.40	4.87
3. Child-related display	4.32	5.21
4. Indoor space arrangement	4.92	5.87
5. Active physical play	3.63	4.20
6. a) Space to be alone (infants and toddlers)	3.50	4.82
6. b) Space to be alone (2 years and older) A52	5.45	5.67
7. Arriving/leaving	6.78	6.92
8. Meals/snacks	3.28	3.67
9. Nap/rest	4.11	3.53
10. Diapering/toileting	1.70	2.27
11. Personal grooming	2.72	3.27
12. Health	4.21	4.47
13. Safety	3.16	3.21
14. a) Informal use of language (infants/toddlers)	6.17	5.83
14. b) Informal use of language (2 yrs and older)	5.59	5.53
15. a) Helping children understand language (infants/toddlers)	5.44	5.17
15. b) Helping children understand language (2 years and older)	5.36	6.13
16. Helping children use language	5.92	5.87
17. Helping children reason (using concepts)	5.64	5.57
18. Eye-hand coordination	5.20	5.87
19. Art	5.54	5.67
20. Music and movement	5.88	5.80
21. Sand and water play	5.72	6.40
22. Dramatic play	5.00	6.13
23. Blocks	4.92	5.07
24. Use of TV	4.52	4.85

Figure A.8 *(continued)*
FDCRS Item Scores
(Round One Observations)

FDCRS Item	Average Score Round 1 (N=25)	Average Score Round 2 (N=15)
25. Schedule of daily activities	6.16	5.87
26. Supervision of play indoors and outdoors	5.12	5.93
27. Tone	5.92	6.60
28. Discipline	5.56	5.80
29. Cultural awareness	4.44	4.47
30. Relationship with parents	6.50	6.87
31. Balancing personal and caregiving responsibilities	6.46	6.73
32. Opportunities for professional growth	6.96	6.73
33. Adaptations for basic care (physically handicapped)	NA	NA
34. Adaptations for activities (physically handicapped)	NA	NA
35. Adaptations for other special needs	6.00	NA
36. Communication (exceptional)	6.00	NA
37. Language/reasoning (exceptional)	5.67	NA
38. Learning and play activities (exceptional)	5.83	NA
39. Social development (exceptional)	6.33	NA
40. Caregiver preparation	5.83	NA

Figure A.9
ITERS Item Scores
(Round One Observations)

ITERS Item A148	**Average Score Round 1 (N=4)**	**Average Score Round 2 (N=4)**
1. Indoor space	7.00	6.00
2. Furniture for routine care and play	4.75	5.75
3. Provision for relaxation and comfort	6.50	6.75
4. Room arrangement	7.00	7.00
5. Display for children	5.50	4.75
6. Greeting/departing	7.00	7.00
7. Meals/snacks	6.25	4.75
8. Nap	4.50	5.75
9. Diapering/toileting	2.75	4.50
10. Health practices	5.50	5.00
11. Safety practices	5.25	5.50
12. Helping children understand language	6.75	6.75
13. Helping children use language	6.75	7.00
14. Using books	5.75	6.25
15. Fine motor	7.00	7.00
16. Active physical play	6.00	7.00
17. Art	5.50	7.00
18. Music and movement	6.00	4.50
19. Blocks	4.25	4.50
20. Dramatic play	6.00	6.75
21. Sand and water play A171	6.33	7.00
22. Nature/science	4.50	6.25
23. Use of TV, video, and/or computer A102	7.00	NA
24. Promoting acceptance of diversity	7.00	6.25
25. Supervision of play and learning	7.00	7.00
26. Peer interaction	6.00	6.75
27. Staff-child interaction	6.75	7.00
28. Discipline	6.75	7.00

Figure A.9 *(continued)*
ITERS Item Scores
(Round One Observations)

ITERS Item	Average Score Round 1 (N=4)	Average Score Round 2 (N=4)
29. Schedule	7.00	6.25
30. Free play	7.00	7.00
31. Group play activities	7.00	7.00
32. Provisions for children with disabilities	NA	NA
33. Provisions for parents	7.00	6.25
34. Provisions for personal needs of staff	5.25	3.33
35. Provisions for professional needs of staff	6.25	6.00
36. Staff interaction and cooperation	6.25	7.00
37. Staff continuity	7.00	7.00
38. Supervision and evaluation of staff	7.00	7.00
39. Opportunities for professional growth	6.75	6.67

Additional Tables on Program Improvement Based on Participant Survey Results

Figure A.10
Improvements Identified by Centers
(N = 73)

For each of the following, please check the box that indicates how much each of the following improved as a result of the Accreditation Project:	Not at all improved by the CDFAP	Improved very little by the CDFAP	Improved moderately by the CDFAP	Improved a great deal by the CDFAP
Your space and materials	0.0	11.0	41.1	47.9
Your program activities	5.5	23.3	45.2	26.0
Your/your staff's interactions with the children	6.8	17.8	49.3	26.0
Your/your staff's relationships with parents	8.2	24.7	38.4	28.8
Your relationships with others in the child care field	9.6	24.7	46.6	19.2
Your/your staff's knowledge about quality child care	6.8	15.1	39.7	38.4
Your administration/management of the program	6.8	15.1	50.7	27.4
Your/your staff's use of other resources in the community such as resource/ referral agencies, grants, classes, etc.	13.7	39.7	23.3	23.3
Your/your staff's commitment to remaining in the child care field	16.4	21.9	31.5	30.1
Your ability to become accredited	1.4	8.2	20.5	69.9

Figure A.11
Improvements Identified by Family Child Care Homes
(N = 70)

For each of the following, please check the box that indicates how much each of the following improved as a result of the Accreditation Project:	Not at all improved by the CDFAP	Improved very little by the CDFAP	Improved moderately by the CDFAP	Improved a great deal by the CDFAP
Your space and materials	0.0	11.4	28.6	60
Your program activities	2.9	17.1	34.3	45.7
Your/your staff's interactions with the children	10.0	18.6	31.4	40.0
Your/your staff's relationships with parents	8.6	22.9	28.6	40.0
Your relationships with others in the child care field	11.4	14.3	31.4	42.9
Your/your staff's knowledge about quality child care	8.6	11.4	24.3	55.7
Your administration/management of the program	5.7	11.4	31.4	51.4
Your/your staff's use of other resources in the community such as resource/referral agencies, grants, classes, etc.	12.9	12.9	28.6	45.7
Your/your staff's commitment to remaining in the child care field	5.7	10.0	24.3	60.0
Your ability to become accredited	4.3	8.6	17.1	70.0